Journal of the Senate

Number 5—Special Session E **Tuesday, March 31, 1992**

CALL TO ORDER

The Senate was called to order by the President at 10:00 a.m. A quorum present—40:

Madam President	Davis	Jennings	Plummer
Bankhead	Diaz-Balart	Johnson	Scott
Beard	Dudley	Kirkpatrick	Souto
Bruner	Forman	Kiser	Thomas
Burt	Gardner	Kurth	Thurman
Casas	Girardeau	Langley	Walker
Childers	Gordon	Malchon	Weinstein
Crenshaw	Grant	McKay	Weinstock
Crotty	Grizzle	Meek	Wexler
Dantzler	Jenne	Myers	Yancey

PRAYER

The following prayer was offered by James C. Vaughn, Jr., Reading Clerk:

Heavenly Father, before addressing the business that is before us today, we humbly pause to stretch our feeble hands to you because there is no other help we know. As these men and women of the Florida Senate are far away from their families, Father, give them the faith to face the unpredictable future.

Heavenly Father, with the many perplexing and seemingly never ending issues that face them as lawmakers of this state, remind them that the tragedy of life is not in their failure, but rather in their complacency; it is not in their doing too much, but rather in their doing too little; not in their living above their ability, but rather in their living and performing below their capacities.

In his holy name we humbly submit ourselves. Amen.

PLEDGE

The Senate pledged allegiance to the flag of the United States of America.

MOTION TO INTRODUCE RESOLUTION

On motion by Senator Scott, by the required constitutional two-thirds vote the following resolution was admitted for introduction:

By Senators Scott, Gordon, Dudley, Crenshaw, Grant, Langley, Casas, Johnson, Bankhead, Souto, Burt and Myers—

SR 46-E—A resolution urging the Governor to convene the Legislature to consider legislative reapportionment.

WHEREAS, constitutional and judicial deadlines require the Legislature to begin the legislative reapportionment as soon as possible, and

WHEREAS, a three-judge panel of the United States District Court for the Northern District of Florida, Tallahassee Division, on March 27, 1992, in the case of Miguel De Grandy, et al., v. T. K. Wetherell, et al., required all plans to be submitted by April 17, 1992, and a final report by May 15, 1992, and

WHEREAS, the Legislature is presently assembled and can begin deliberations immediately upon the call of the Governor pursuant to Section 16 of Article III of the State Constitution, NOW, THEREFORE,

Be It Resolved by the Senate of the State of Florida:

That the Senate urges the Governor to call a special session of the Legislature to consider legislative reapportionment pursuant to Section 16 of Article III of the State Constitution to begin April 1, 1992, at 12 noon or at the earliest possible time thereafter.

—was read the first time in full. On motion by Senator Scott, the rules were waived and **SR 46-E** was read the second time by title and adopted. The vote on adoption was:

Yeas—32 Nays—7

On motion by Senator Jenne, the following remarks regarding **SR 46-E** were published in the Journal:

Senator Scott: Madam President, at the appropriate time before we adjourn, I think we should consider a Senate Resolution asking the Governor of Florida to perform his duty as prescribed in the Constitution and call us in tomorrow, in view of the schedule set by the federal court, for legislative reapportionment, without regard to all these games about these bills, all of which could be taken up later. I believe the vote on that might be pretty significant in here.

Madam President: The Governor has to call us back. It doesn't have to be the 8th. The final day would be the 15th of May. You know, he has to call us sometime within 30 days.

Senator Scott: Madam President, and with all due respect to you, Governor, if you're watching, I feel that in view of the schedule—and the Governor wasn't over there as some of us were—set by the court, the courts have recognized throughout all the decisions that it's a duty of elected officials to do reapportionment and the court shouldn't get involved unless we fail. For the Governor to say he is going to let us sit here for a week when he has a mandatory duty under the Constitution is not a proper course and I hope he will rethink that. I think we should do a resolution urging him to perform his duty and call us in on legislative reapportionment. To wait a week puts us in a deadline crisis He might as well sign a letter telling us, "I'm sending it to the federal courts, forget you guys, forget the people of Florida that sent you up here." I hope he won't do that.

Senator Langley: I do now move, Madam President, that we adjourn, sine die. I want to amend that to read, after the resolution of Senator Scott, we do adjourn, sine die. The resolution only provides that the Governor call us right back into session.

Madam President: I don't see any resolution. I don't have any resolution, Senator Langley.

Senator Scott: Madam President, the bill drafting guy has it, I don't know where he went. If he's in the sound of my voice he needs to bring it back but it was in the process of being drafted and essentially what it will say is that we're all here to perform our duties and the federal court has established the guidelines that were set forth in their order, including plan submission by April 17th and final Master's report by May 15th and that under the Constitution we won't have time to get something and get it through the Supreme Court unless we start immediately and do something within the next several days. That's what the resolution will say.

Madam President: I certainly didn't have the feeling that the Governor was at all urgent about calling us back and he understood the seriousness of the situation.

Senator Scott: Madam President, we now have on the desk the resolution which says what we described before. I move that we introduce Senate Resolution Number 46 which is a resolution to the Governor asking him to convene the Legislature in legislative reapportionment session.

Madam President: Any objection to taking the resolution up? Without objection, read the resolution.

Senator Jenne: Madam President, could you supply me with a copy of that so I would have the opportunity to read it?

Senator Scott: Madam President, it's hand written is the reason he read it in full. There is one statement in it that needs to be changed because it says that, "whereas the court ordered us to submit a plan." What the court did, and their order said, "all plans are to be submitted by April 17th," and we need to make that correction on the resolution.

Madam President: I would assume that the best way to do this, Senator, is to recess for awhile.

Senator Dantzler: I rise to speak to the resolution, Madam President. Senators, doesn't it make more sense if our objective is to somehow get into special session tomorrow on the legislative reapportionment plan, don't we maximize our chances by passing the resolution and considering today a couple of those bills that Senator Thomas has recommended that we consider? Now it has been represented to this body that they are not controversial. If they are, the controversy can't be too great and I feel certain that we can cure that controversy if there is controversy attached to those things. But we need to understand that once that special session on legislative reapportionment begins we can't do anything else for potentially up to 30 days. Doesn't it make sense if we're going to be back into session tomorrow not to adjourn sine die in just a few minutes and fly back home this afternoon and fly back up here again in the morning if the Governor does call the special session on legislative reapportionment to begin at some point tomorrow? Don't we maximize our chances by passing the resolution which has been offered by Senator Scott to let the Governor know exactly how this body feels about that issue while we're up here waiting on that call to do some of these things which Senator Thomas has recommended that we do? I think that makes sense. I think that's the most prudent thing. I can't think of anything more unproductive than to leave in just a few minutes and go back home and have to fly back in the morning or not fly home this afternoon and sit around here all afternoon and in the morning and do nothing. That, to me, would seem to be the most unproductive thing, Senator Bruner, so let's pass the resolution as offered by Senator Scott. Let's deal with some of those bills as offered by Senator Thomas. I think that maximizes our chances of getting into the legislative reapportionment session tomorrow.

Senator Scott: I would like to ask everybody to be co-sponsors or show it reintroduced by everybody that wants to introduce it because I don't want this in any way to be just my idea. I think everybody in here wants to do it. The other thing I would like to say is that a date was set, April 8th, regardless of whether that was right or wrong. Since that date we've had this court decision. They set a schedule and they have said, for example, no replies will be permitted to responses to summary judgment. Very unusual, I mean they are clearly not going to change any of these deadlines. The counsel said it's too early, we can't possibly by next Tuesday have answers to an 80 page complaint. They said, "We've already ruled on that, counsel, you'll have your answer by next week." The court has clearly set these deadlines and if we are to have an opportunity to do this we have to get in session right away. I would invite everybody to be a co-sponsor of the resolution because it's not just one idea or a partisan idea or anything else. I think that most people in here have been saying ever since we have been here we want to get to legislative reapportionment.

Madam President: Senator Scott, I want to reiterate that I don't believe the Governor feels the least bit urgent about moving up that date. It's just to the general mood in here. You need to understand the seriousness of what you are doing. I don't think the Governor's real happy with Republicans right now.

Senator Scott: Madam President, some Republicans might reciprocate that, but not me. I feel like the Governor, who I've known for twenty years, has stated his position that we ought to get on with it and, in view of this court decision, regardless of the discussions this morning, I feel that he will do what he said and give us a chance to do that. Otherwise it will be, in effect, the Governor sending this to the Supreme Court, so I just think we have a duty to ask. The fact is, it's our constituents that have the concern, and each one of us has been sent here by majority vote of our constituents. They asked us to do this, and they have been writing me by the hundreds about the congressmen and whatever. They want us to act on their behalf. They do not want a court, unless it is just absolutely impossible for us to act, they don't want a court to step in and determine who they get a chance to vote for or what areas they are lumped with in voting. So, regardless of what you may think that the Governor thinks of Republicans, I really feel like people are the question here, and regardless of what he might or might not feel about anyone of us, it's the people's prerogative that we are talking about, and we ought to try to do it. If we can't do it, we can't do it, then fine. The Constitution that the people adopted says that the court can then try to do it.

Senator Crenshaw: Madam President, Members, I want to speak in favor of the resolution and I want to speak in favor of the motion to adjourn sine die. The overriding concern here that all of us ought to have is the fact that the court took jurisdiction over congressional reapportionment and legislative reapportionment and the reason they took jurisdiction is because we weren't getting the job done. The reason they took control is because they are trying to look out for the voters of Florida—all the voters. If we pass this resolution and we adopt the motion to adjourn, we send a very clear signal that this body, this Senate, is ready, it's willing and it's able to go about the work that a federal court has said is the most important thing to be done right now. I think what we will do when we do this is make it crystal clear that we're ready and it will put the ball in the Governor's court. It will put the Governor in the driver's seat as to whether we continue on to do the work that a federal court has said is very important. If the Governor decides that he wants to wait until next Wednesday, he's in the driver's seat. If he wants to wait the full thirty days, he's in the driver's seat, but if he, after he understands that it's crystal clear that it's his call, wants to cooperate with the people of Florida, with the Senate and with the federal courts, then I think he will call us back as soon as he can. On the issue of all these other bills, or hand full of bills, I don't know what's in those bills. We've spent sixty days here. We've passed some bills. We didn't pass other bills, and now we've got one or two that somebody decides are just critical before we can leave this place. I think we all know the only reason they are critical is because the Governor feels like since he is going to be in the driver's seat, he can demand one or two or three or four, but I really don't think that's the issue at all. The issue is to get on with the business that's important to the people of this state—to the voters—to make sure they have a fair plan that gives them all the right to vote. So having said that, Madam President, I would continue to ask every member of this body, by becoming co-sponsors of the resolution, to say that we want the world to know that we think it is important to get on with the business of the people. The federal court has said that, and that makes it crystal clear to the Governor, that it's his call. He is driving the train and he'll call us back when he sees fit.

Senator McKay: Madam President, I would like to offer a substitute motion and I believe there is some support for it, that we take up House Bill 43-E, Senate Bill 44-E, both of which have been discussed in this body.

Senator Scott: His motion would be in order after we finish on the resolution.

Madam President: We're on the resolution.

Senator Scott: I moved the resolution, Madam President, and I would ask that if everybody wants to be co-introducers...

Senator Childers: Senators, I'm going to say something, I think you need to listen to it and listen very carefully. I'm going to ask you, I don't usually do this but please, please give me your attention. I just went to the rostrum with permission of the President and called the Governor and the Governor said there are four non-controversial measures—one had an amendment that needed to come off, that was one person's amendment—but there are four measures that he would like to see passed in this session—the two health care bills, coastal zone management and the DOA/DGS reorg bill. Now there are not a lot of problems with these bills as I understand it. They have gone through committees. If there are problems, maybe we can debate them, maybe we can settle them, but the Governor said emphatically that he will take nothing less than those four that he considers to be essential, that he considers to be important and that he considers us to have the time to do. The decision is not up to me and I'm not trying to encourage you to vote for or against a resolution of these bills. Everyone is on his own, but this is a statement from the Governor and he just told me that and gave me permission to restate it on the floor.

Madam President: He's not going to call us back.

Senator Childers: He's not going to call us until his time schedule. I don't anticipate him doing that based on a resolution. I just wanted to know and hear it with my own ears what the Governor said and he just told me that.

Senator Grant: Did I understand you, Senator Childers, to say that the quid pro quo was that if we don't pass his four bills, he won't call us into session.

Senator Childers: He will not change his schedule.

Senator Grant: So, he is trying to blackmail the Legislature?

Senator Childers: No, he is doing pretty much what we all do at times.

Senator Grant: You know, Senator Childers, I respect the division of power and I respect the Executive branch and the Legislative branch and the Judicial branch, but the Governor is trying to run the Senate right now. He is trying to hot box us. I've got one of those four bills and I think it is a very important bill that ought to pass, but it's time will come and if the Governor is going to try to hold us hostage I will just withdraw that bill.

Senator Childers: The Senate and the House is trying to run the Governor and he just doesn't seem to move much. That is where we are.

Senator Langley: I yield to Senator Scott to move the resolution. That's what should be the order of business.

Senator Scott: Madam President, I move the resolution.

Senator Jenne: I think there was a desire on the part of the Senate obviously to send a message to the Governor. I think probably the best way to reflect that is I would like to move that the comments made in the debate concerning the resolution, up to and including it, be spread upon the record.

MOTION TO ADJOURN

Senator Langley moved that the Senate in special session adjourn sine die. The motion failed. The vote was:

Yeas—20 Nays—20

MOTIONS RELATING TO COMMITTEE REFERENCE

On motions by Senator Thomas, by two-thirds vote **SB 44-E** was withdrawn from the Committees on Health and Rehabilitative Services; and Judiciary; **HB 43-E** was withdrawn from the Committee on Health and Rehabilitative Services; and **SB 28-E** was withdrawn from the Committee on Natural Resources and Conservation.

MOTION

On motion by Senator Thomas, the rules were waived and the Special Order Subcommittee of the Committee on Rules and Calendar was granted permission to meet immediately upon adjournment this day.

RECESS

On motion by Senator Thomas, the Senate recessed at 12:11 p.m. to reconvene at 2:00 p.m.

CALL TO ORDER

The Senate was called to order by the President at 2:00 p.m. A quorum present—40:

Madam President	Davis	Jennings	Plummer
Bankhead	Diaz-Balart	Johnson	Scott
Beard	Dudley	Kirkpatrick	Souto
Bruner	Forman	Kiser	Thomas
Burt	Gardner	Kurth	Thurman
Casas	Girardeau	Langley	Walker
Childers	Gordon	Malchon	Weinstein
Crenshaw	Grant	McKay	Weinstock
Crotty	Grizzle	Meek	Wexler
Dantzler	Jenne	Myers	Yancey

SPECIAL ORDER

HB 43-E—A bill to be entitled An act relating to health care; revising and reorganizing chapter 395, F.S.; providing for part I of said chapter, relating to hospitals and other licensed facilities; amending s. 395.002, F.S.; revising definitions; amending s. 395.003, F.S.; revising licensure provisions; amending s. 395.004, F.S., relating to application for license; providing a fee for provisional licensure of a health care facility; amending and renumbering s. 395.006, F.S.; revising provisions relating to licensure inspection; providing criteria; amending and renumbering s. 395.008, F.S., relating to inspection reports; providing a maximum copying fee; amending and renumbering s. 395.007, F.S.; deleting authority to delegate review of plans and specifications to a county or municipality; amending and renumbering s. 395.011, F.S.; modifying provisions relating to staff membership and clinical privileges; amending and renumbering s. 395.0115, F.S., relating to peer review and disciplinary powers; amending and renumbering s. 395.014, F.S., relating to access of chiropractors to diagnostic reports; amending and renumbering s. 395.041, F.S., relating to internal risk management programs; limiting responsibilities of part-time risk managers; providing for annual, rather than quarterly, reports to the Department of Professional Regulation; changing procedure for reports of adverse or untoward incidents; providing for administrative fine by the Department of Professional Regulation; requiring the Department of Health and Rehabilitative Services to publish an annual summary of incident reports; deleting a requirement relating to information bulletins; amending and renumbering s. 395.0172, F.S., relating to private utilization review; deleting duplicate language; amending and renumbering s. 395.0101, F.S., relating to treatment of biomedical waste; amending and renumbering s. 395.0201, F.S.; requiring certain facilities to treat and protect the anonymity of sexual assault victims; amending and renumbering s. 395.0205, F.S.; requiring protocols for the treatment of victims of child abuse or neglect; renumbering s. 395.0147, F.S., relating to notification to emergency medical personnel of exposure to infectious diseases; amending and renumbering s. 395.038, F.S., relating to regional poison control centers; amending and renumbering s. 395.0142, F.S.; expanding requirements for providing access to emergency services; providing for inventory of hospital emergency services; revising provisions relating to legislative intent, medically necessary transfers, discrimination, liability, and records; prohibiting retaliation for patient transfers; providing penalties; providing for civil actions; requiring reports; amending and renumbering s. 395.0175, F.S., relating to complaint investigation procedures; amending and renumbering s. 395.005, F.S., relating to rules and enforcement; providing for standards for the use of seclusion and restraint; providing for hospital quality improvement programs; amending and renumbering s. 395.018, F.S.; increasing fines for operating without a license; increasing an administrative fine; also including within part I of chapter 395, F.S., ss. 395.001, 395.009, and 395.0185, F.S., relating to legislative intent, minimum standards for clinical laboratory tests, and prohibitions and penalties for rebates; amending and renumbering s. 395.015, F.S., relating to itemized patient bills; providing for a copy to the physician, upon request; revising applicability; providing certain liability; renumbering s. 395.016, F.S., relating to content of patient records; renumbering s. 395.0165, F.S., relating to penalties for altering patient records; amending and renumbering s. 395.017, F.S.; revising requirements for disclosure of patient records; providing charges for copies and searches of records; providing exemptions; creating s. 395.304, F.S.; providing for additional regulatory studies; requiring a report; providing for part II of said chapter, relating to trauma; amending and renumbering s. 395.031, F.S.; revising definitions; providing additional component of trauma care system plans; specifying a period for approval of plans; providing for hearings; renumbering s. 395.032, F.S., relating to state regional trauma planning; amending and renumbering s. 395.033, F.S., relating to trauma service areas; amending and renumbering s. 395.0335, F.S.; revising provisions relating to selection of state-approved trauma centers; revising provisions relating to notice of termination of operation; providing certain immunity from liability for out-of-state experts; renumbering ss. 395.034 and 395.0345, F.S., relating to reimbursement of centers and the Trauma Services Trust Fund, respectively; amending and renumbering s. 395.035, F.S., relating to review of trauma registry data; providing for trauma transport protocols for use of air ambulance service; renumbering s. 395.036, F.S., relating to transport of trauma victims to centers; providing for trauma transport protocols for use of air ambulance service; renumbering and amending s. 395.037, F.S., relating to rulemaking authority; providing for part III of said chapter, relating to rural hospitals; amending and renumbering s. 395.102, F.S.; providing definitions; deleting certain limitations on rural hospital swing bed length of stay; renumbering s. 395.103, F.S., relating to rural hospital impact statements; amending and renumbering ss. 395.104 and 395.01465, F.S., relating to other rural hospital programs and emergency care hospitals, respectively; providing for part IV of said chapter, relating to the Public Medical Assistance Trust Fund; amending and renumbering s. 395.101, F.S., relating to hospital annual assessments; providing liability for fines, penalties, and assessments upon transfer or termination of a facility; providing alternative payment method for certain statutory teaching hospitals; renumbering s. 395.1015, F.S., relating to annual assessments of other health care entities; clarifying an exemption for blood and plasma centers; exempting certain clinical laboratories; providing an exclusion for out-of-state reve-

nues; specifying the types of radiological services to be included in the assessment; clarifying that only licensed facilities shall be subject to the assessment; providing for part V of said chapter, relating to medical education and tertiary care; amending and renumbering ss. 395.60 and 395.62, F.S., relating to short title and the Medical Education and Tertiary Care Trust Fund, respectively; renumbering ss. 395.61 and 395.63, F.S., relating to legislative intent and distribution of trust fund moneys, respectively; repealing ss. 395.012 and 395.013, F.S., relating to prohibitions against interference with the prescription of amygdalin (laetrile) or dimethyl sulfoxide (DMSO); repealing s. 395.0143, F.S., relating to denial of emergency treatment; repealing s. 395.0144, F.S., relating to duty to admit or transfer emergency patients; repealing s. 395.0146, F.S., relating to certificates of need for emergency services; amending ss. 119.07, 240.4067, 320.0801, 322.0602, 381.004, 381.026, 381.703, 381.706, 383.336, 394.463, 394.4787, 394.4789, 401.425, 401.48, 407.002, 407.51, 409.918, 440.13, 440.185, 458.331, 459.015, 461.013, 626.941, 626.943, 641.55, 766.101, 766.110, and 766.314, F.S.; correcting cross references; providing an appropriation; saving specified provisions from Sunset repeal; providing for review and repeal; providing a disclaimer; providing an effective date.

—was read the second time by title.

Senator Malchon moved the following amendment:

Amendment 1 (with Title Amendment)—Strike everything after the enacting clause and insert:

Section 1. Section 395.002, Florida Statutes, is amended to read:

395.002 Definitions.—As used in this chapter, *the term*:

(1) "Accrediting organizations" means the Joint Commission on Accreditation of *Healthcare Organizations* ~~Hospitals~~, the American Osteopathic Association, *the Commission on Association of Rehabilitation Facilities,* and the Accreditation Association for Ambulatory Health Care, *Inc.*

(2) "Adverse or untoward incident," for purposes of reporting to the department, means an event over which health care personnel could exercise control, which is probably associated in whole or in part with medical intervention rather than the condition for which such intervention occurred, which causes injury to a patient, and which:

(a) Is not consistent with or expected to be a consequence of such medical intervention;

(b) Occurs as a result of medical intervention to which the patient has not given his informed consent;

(c) Occurs as the result of any other action or lack of any other action on the part of the hospital or personnel of the hospital;

(d) Results in the performance of a surgical procedure on the wrong patient; or

(e) Results in the performance of a surgical procedure that is unrelated to the patient's diagnosis or medical needs.

(3) ~~(2)~~ "Ambulatory surgical center" means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day *and is not permitted to stay overnight*, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003~~(2)~~.

(4) "At service capacity" means the temporary inability of a hospital to provide a service that is within the service capability of the hospital, due to maximum use of the service at the time of the request for the service.

(5) "Biomedical waste" means any solid or liquid waste that may present a threat of infection to humans. The term includes, but is not limited to, nonliquid human tissue and body parts; laboratory and veterinary waste that contains human-disease-causing agents; used disposable sharps; human blood, human blood products, and body fluids; and other materials that in the opinion of the department represent a significant risk of infection to persons outside the waste-producing facility.

(6) "Clinical privileges" means the privileges granted to a physician or other licensed health care practitioner to render patient care services in a hospital, but does not include the privilege of admitting patients.

(7) ~~(3)~~ "Department" means the Department of Health and Rehabilitative Services.

(8) "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(9) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

(10) ~~(4)~~ "General hospital" means any facility which meets the provisions of subsection *(12)* ~~(6)~~ and which regularly makes its facilities and services available to the general population.

(11) ~~(5)~~ "Governmental unit" means the state or any county, municipality, or other political subdivision, or any department, division, board, or other agency of any of the foregoing.

(12) ~~(6)~~ "Hospital" means any establishment that:

(a) Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and

(b) Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent.

However, the provisions of this chapter do not apply to any institution conducted by or for the adherents of any well-recognized church or religious denomination *that depends* ~~for the purpose of providing facilities for the care or treatment of the sick who depend~~ exclusively upon prayer or spiritual means *to heal, care for, or treat any person* ~~for healing in the practice of the religion of such church or denomination~~. *For purposes of local zoning matters, the term "hospital" includes a medical office building that is located on the same premises as a hospital facility provided the land upon which the medical office building is constructed is currently zoned for use as a hospital; provided the premises were zoned for hospital purposes on January 1, 1992.*

(13) ~~(7)~~ "Hospital bed" means *a hospital* ~~an~~ accommodation which is ready for immediate occupancy, or is capable of being made ready for occupancy within *48* ~~24~~ hours, excluding provision of staffing, and which conforms to minimum space, equipment, and furnishings standards as specified by rule of the department for the provision of *services specified in this section* ~~medical and nursing care~~ to a single patient.

(14) "Initial denial determination" means a determination by a private review agent that the health care services furnished or proposed to be furnished to a patient are inappropriate, not medically necessary, or not reasonable.

(15) "Injury," for purposes of reporting to the department, means any of the following outcomes if caused by an adverse or untoward incident:

(a) Death;

(b) Brain damage;

(c) Spinal damage;

(d) Permanent disfigurement;

(e) Fracture or dislocation of bones or joints;

(f) Any condition requiring definitive or specialized medical attention that is not consistent with the routine management of the patient's case or patient's preexisting physical condition;

(g) Any condition requiring surgical intervention to correct or control;

(h) Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care;

(i) Any condition that extends the patient's length of stay; or

(j) Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility.

(16)~~(8)~~ "Intensive residential treatment programs for children and adolescents" means a specialty hospital accredited by the Joint Commission on Accreditation of *Healthcare Organizations* ~~Hospitals~~ which provides 24-hour care and which has the primary functions of diagnosis and treatment of patients under the age of 18 having psychiatric disorders in order to restore such patients to an optimal level of functioning.

(17)~~(9)~~ "Licensed facility" means a hospital or ambulatory surgical center licensed in accordance with this chapter.

(18)~~(10)~~ "Life safety" means the control and prevention of fire and other life-threatening conditions *on a premises for the purpose of preserving human life* ~~in buildings for the preservation of human life and the preservation of property~~.

(19) "Medical staff" means physicians licensed under chapter 458 or chapter 459 who have privileges in a licensed facility and other licensed health care professionals who have clinical privileges as approved by a licensed facility's governing board.

(20) "Medically necessary transfer" means a transfer of a patient made necessary because the patient is in immediate need of treatment for an emergency medical condition for which the facility lacks service capability or is at service capacity.

(21)~~(11)~~ "Person" means any individual, ~~firm,~~ partnership, corporation, ~~company,~~ association, *or governmental unit* ~~institution, or joint stock association, and any legal successor thereof~~.

(22)~~(12)~~ "Premises" means those buildings, beds, and *equipment* ~~facilities~~ located at the ~~main~~ address of the *licensed facility* ~~licensee~~ and all other buildings, beds, and *equipment* ~~facilities~~ for the provision of hospital *or ambulatory surgical* care located in such reasonable proximity to the ~~main~~ address of the *licensed facility* ~~licensee~~ as to appear to the public to be under the dominion and control of the licensee.

(23) "Private review agent" means any person or entity that performs utilization review services for third-party payors pursuant to a contract for outpatient or inpatient services. However, the term does not include full-time employees, personnel, or staff or health insurers, health maintenance organizations, or hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, when performing utilization review for their respective hospitals, health maintenance organizations, or insureds of the same insurance group. For this purpose, health insurers, health maintenance organizations, and hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, include such entities engaged as administrators of self-insurance as defined in s. 624.031.

(24) "Service capability" means all services offered by the facility in which identification of services offered is evidenced by the appearance of the service in a patient's medical record or itemized bill.

(25) "Specialty bed" means a bed, other than a general bed, designated on the face of the hospital license for a dedicated use.

~~(13)(a) "Solid waste" means any solid material emanating from patient care, which includes, but is not limited to, the following disposables: linens, gowns, intravenous material, catheters, syringes, needles, clinical laboratory specimen containers, tubes, drainage systems, renal dialyzers and accessories, and other disposable items which may be contaminated with urine, feces, blood, secretions, or other bodily fluids.~~

~~(b) "Liquid waste" means any material emanating from patient care that may be and is routinely placed into the sewerage system, which includes, but is not limited to, urine, feces, blood, secretions, drainage fluids, and other bodily fluids.~~

~~(c) "Biohazardous waste" means any solid or liquid waste which may present a threat of infection to humans. The term includes, but is not limited to, nonliquid human tissue and body parts; laboratory and veterinary waste which contains human disease-causing agents; used disposable sharps; human blood, and human blood products and body fluids; and other materials which in the opinion of the department represent a significant risk of infection to persons outside the generating facility.~~

(26)~~(14)~~ "Specialty hospital" means any facility which meets the provisions of subsection *(12)* ~~(6)~~, and which regularly makes available either:

(a) The range of medical services offered by general hospitals, but restricted to a defined age or gender group of the population; ~~or~~

(b) A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; *or.*

(c) Intensive residential treatment programs for children and adolescents.

(27) "Stabilized" means, with respect to an emergency medical condition, that material deterioration of the condition is not likely, within reasonable medical probability, to result from the transfer of the patient from a hospital.

(28) "Utilization review" means a system for reviewing the medical necessity or appropriateness in the allocation of health care resources of hospital services that are given or proposed to be given to a patient or group of patients.

(29) "Utilization review plan" means a description of the policies and procedures governing utilization-review activities performed by a private review agent.

(30) "Validation inspection" means an inspection of the premises of a licensed facility by the department to assess whether a review by an accrediting organization has adequately evaluated the licensed facility according to minimum state standards.

~~(15) "Emergency care hospital" means a medical facility which provides:~~

~~(a) Emergency medical treatment; and~~

~~(b) Inpatient care to ill or injured persons prior to their transportation to another hospital or provides inpatient medical care to persons needing care for a period of up to 96 hours. The 96-hour limitation on inpatient care does not apply to respite, skilled nursing, hospice, or other nonacute care patients.~~

~~(16) "Rural primary care hospital" means any facility meeting the criteria in s. 395.01465(1) or s. 395.102(2)(a) which provides:~~

~~(a) Twenty-four-hour emergency medical care;~~

~~(b) Temporary inpatient care for periods of 72 hours or less to patients requiring stabilization before discharge or transfer to another hospital. The 72-hour limitation does not apply to respite, skilled nursing, hospice, or other nonacute care patients; and~~

~~(c) Has no more than six licensed acute care inpatient beds.~~

~~(17) "Essential access community hospital" means any facility which:~~

~~(a) Has at least 100 beds;~~

~~(b) Is located more than 35 miles from any other essential access community hospital, rural referral center, or urban hospital meeting criteria for classification as a regional referral center;~~

~~(c) Is part of a network that includes rural primary care hospitals;~~

~~(d) Provides emergency and medical backup services to rural primary care hospitals in its rural health network;~~

~~(e) Extends staff privileges to rural primary care hospital physicians in its network; and~~

~~(f) Accepts patients transferred from rural primary care hospitals in its network.~~

Section 2. Section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; issuance, renewal, denial, and revocation.—

(1)(a) No person ~~or governmental unit~~ shall establish, conduct, or maintain a *licensed facility* ~~hospital or ambulatory surgical center~~ in this state without first obtaining a license under this part.

(b)1. It is unlawful for any person to use or advertise to the public, in any way or by any medium whatsoever, any facility as a "hospital" or "ambulatory surgical center" unless such facility has first secured a license under the provisions of this part.

2. Nothing in this part applies to veterinary hospitals or to commercial business establishments using the word "hospital" or "ambulatory surgical center" as a part of a trade name if no treatment of human beings is performed on the premises of such establishments.

(2)(a) Upon the receipt of an application for *a* license and the license fee, the department shall issue a license if the applicant and ~~hospital or ambulatory surgical center~~ facility have received all approvals required by law and meet the requirements established under this part and in rules ~~promulgated hereunder~~.

~~(b) The department shall provide, by rule, for licensure of any ambulatory surgical center which is certified or seeks certification as a Medicare ambulatory surgical center and meets basic standards which will ensure the safe and adequate care of persons receiving ambulatory surgical services.~~

(b)~~(c)~~ *A* provisional *license* ~~licenses~~ may be issued to *a* new *facility* ~~hospitals~~ or *a facility that is* ~~hospitals that are~~ in substantial compliance with this part and with the rules of the department. A provisional license shall be granted for a period of no more than 1 year and shall expire automatically at the end of its term. *A provisional license may not be renewed.*

(c)~~(d)~~ A license, unless sooner suspended or revoked, shall automatically expire 2 years from the date of issuance and shall be renewable biennially upon application for renewal and payment of the fee prescribed by s. 395.004(2), provided the applicant and *licensed* ~~hospital or ambulatory surgical center~~ facility meet the requirements established under this part and rules promulgated hereunder. An application for renewal of a license shall be made 90 days prior to expiration of the license, on forms provided by the department.

(d)~~(e)~~ The department shall, at the request of a licensee, issue a single license to a licensee for facilities located on separate premises. Such a license shall specifically state *the location of* the facilities, *the* services, and *the* licensed beds available on each separate premises. *If* ~~When~~ a licensee requests a single license, the licensee shall designate which facility or office is responsible for receipt of information, payment of fees, service of process, and all other activities necessary for the department to carry out the provisions of this part.

(e)~~(f)~~ Intensive residential treatment programs for children and adolescents which have received accreditation from the Joint Commission on Accreditation of *Healthcare Organizations* ~~Hospitals~~ and which meet the minimum standards developed by rule of the department for such programs *shall* ~~may~~ be licensed by the department under this part.

(3)(a) Each license shall be valid only for the *person* ~~persons and governmental units~~ to whom it is issued and shall not be *sold, assigned, or otherwise transferred, voluntarily or involuntarily. A license is only valid for the premises* ~~subject to sale, assignment, or other transfer, voluntary or involuntary; and A license shall not be valid for any premises other than that~~ for which it was originally issued.

(b) An application for a new license is required *if the ownership of,* ~~when~~ a majority of the ownership *of,* or controlling interest *in* ~~of~~ a licensed facility is transferred or assigned and when a lessee agrees to undertake or provide services to the extent that legal liability for operation of the facility rests with the lessee. The application for a new license showing such change shall be made at least 60 days prior to the date of the sale, transfer, assignment, or lease.

(4) The department shall issue a license which specifies the *service categories and the number of hospital beds in each bed category for which a license is received. Such information shall be listed* ~~number of hospital beds~~ on the face of the license. ~~The number of beds for the rehabilitation or psychiatric service category for which the department has adopted by rule a specialty bed need methodology under ss. 381.701-381.715 shall be specified on the face of the hospital license.~~ All beds which are not covered by any specialty-bed-need methodology shall be specified as general beds. A licensed facility shall not ~~continuously~~ operate a number of hospital beds greater than the number indicated by the department on the face of the license *without approval from the department under conditions established by rule.*

(5)(a) The rights of persons or patients specified in ss. 394.459, 394.463, 394.465, and 394.467 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment.

(b) Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in s. 394.459.

(6)~~(5)~~ No specialty hospital shall provide any service or regularly serve any population group beyond those services or groups specified in its license.

(7)~~(6)~~ Licenses shall be posted in a conspicuous place on *each of* the licensed premises.

(8)~~(7)~~ Whenever the department finds that there has been a substantial failure to comply with the requirements established under this part or in rules ~~promulgated hereunder~~, the department is authorized to deny, modify, suspend, or revoke:

(a) A license;

(b) That part of a license which is limited to a separate premises, as designated on the license; or

(c) Licensure approval limited to a facility, building, or portion thereof, or a service, within a given premises.

Section 3. Section 395.004, Florida Statutes, is amended to read:

395.004 Application for license, disposition of fees; expenses.—

(1) An application for a license or renewal thereof shall be made *under oath* to the department, upon forms provided by it, and shall contain such information as the department reasonably requires, which may include affirmative evidence of ability to comply with applicable laws and rules.

(2) Each application for a general hospital license, specialty hospital license, or ambulatory surgical center license, or renewal thereof, shall be accompanied by a license fee, in accordance with the following schedule:

(a) The biennial license, *provisional license,* and license renewal fee required of a facility licensed under this part shall be reasonably calculated to cover the cost of regulation under this part and shall be established by rule at the rate of not less than $9.50 per hospital bed, nor more than $30 per hospital bed, except that the minimum license fee ~~hereunder~~ shall be $1,500 and the total fees collected from all licensed facilities may not exceed the cost of properly carrying out the provisions of this part.

(b) Such fees shall be *paid* ~~payable~~ to the department and shall be deposited in the *Planning and Evaluation* ~~Hospital Licensure~~ Trust Fund for the sole purpose of carrying out the provisions of this part.

Section 4. Section 395.006, Florida Statutes, is transferred, renumbered as section 395.0161, Florida Statutes, and amended to read:

395.0161 ~~395.006~~ Licensure inspection.—

(1) The department shall make or cause to be made such inspections and investigations as it deems necessary, *including:*

(a) Inspections directed by the Healthcare Finance Administration.

(b) Validation inspections.

(c) Life-safety inspections.

(d) Licensure complaint investigations, including full licensure investigations with a review of all licensure standards as outlined in the administrative rules. Complaints received by the department from individuals, organizations, or other sources are subject to review and investigation by the department.

(e) Emergency access complaint investigations.

(2)~~(a)~~ The department shall accept, in lieu of its own periodic inspections for licensure, the survey or inspection of an accrediting organization, provided the accreditation of the licensed facility is not provisional and provided the licensed facility authorizes release of, and the department receives the report of, the accrediting organization. *The department shall develop, and adopt by rule, criteria for accepting survey reports of accrediting organizations in lieu of conducting a state licensure inspection.* ~~Reports of accrediting organizations received by the department in lieu of its periodic inspections of licensed facilities for licensure shall not be released publicly in such a manner as to disclose the identity of individuals or licensed facilities, and such information is confidential and exempt from the provisions of s. 119.07(1), except as permitted by the licensed facility or in a proceeding involving the question of licensure. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.~~

~~(b) The department may conduct complaint investigations and sample validation inspections to evaluate the inspection process of hospital accrediting organizations. The department may conduct a life safety inspection in calendar years when a hospital accrediting organization survey is not conducted and may conduct a full state inspection, including life safety, when a hospital accrediting organization survey has not been conducted within the previous 24 months.~~

(3) With the exception of state-operated licensed facilities, each facility licensed under this part shall pay to the department, at the time of inspection, the following fees:

(a) Inspection for licensure.—A fee shall be paid which is not less than $8 per hospital bed, nor more than $12 per hospital bed, except that the minimum fee shall be $400 per facility.

(b) Inspection for life safety only.—A fee shall be paid which is not less than 75 cents per hospital bed, nor more than $1.50 per hospital bed, except that the minimum fee shall be $40 per facility.

~~The fees for fiscal year 1982-1983 shall be the minimum fees prescribed in this subsection, and such fees shall remain in effect until the effective date of a fee schedule promulgated by rule by the department pursuant to this part.~~

(4) The department shall coordinate all periodic inspections for licensure made by the department to ensure that the cost to the facility of such inspections and the disruption of services by such inspections is minimized.

Section 5. Section 395.008, Florida Statutes, is transferred, renumbered as section 395.0162, Florida Statutes, and amended to read:

395 0162 ~~395.008~~ Inspection reports.—

(1) Each licensed facility shall maintain as public information, available upon request, records of all inspection reports pertaining to that facility ~~which have been filed with, or issued by, any governmental agency~~. Copies of such reports shall be retained in its records for not less than 5 years from the date the reports are filed and issued.

(2) Any records, reports, or documents which~~, by state or federal law or regulation, are deemed confidential,~~ are confidential and exempt from ~~the provisions of~~ s. 119.07(1)~~, and~~ shall not be distributed or made available for purposes of compliance with this section unless or until such confidential status expires. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(3) A licensed facility shall, upon the request of any person who has completed a written application with intent to be admitted to such facility, any person who is a patient of such facility, or any relative, spouse, ~~or~~ guardian, *or surrogate* of any such person, furnish to the requester a copy of the last inspection report *filed with or* issued by the department pertaining to the licensed facility, as provided in subsection (1), provided the person requesting such report agrees to pay a reasonable charge to cover copying costs, *which may not exceed $1 per page.*

Section 6. Section 395.007, Florida Statutes, is transferred, renumbered as section 395.0163, Florida Statutes, and amended to read:

395.0163 ~~395.007~~ Construction inspections; plan submission and approval; fees.—

(1) The department shall make, or cause to be made, such construction inspections and investigations as it deems necessary. The department may prescribe by rule that any licensee or applicant desiring to make specified types of alterations or additions to its facilities or to construct new facilities shall, before commencing such alteration, addition, or new construction, submit plans and specifications therefor to the department for preliminary inspection and approval or recommendation with respect to compliance with the rules and standards herein authorized. The department shall approve or disapprove the plans and specifications within 60 days after receipt of the fee for review of plans as required in subsection (2). The department may be granted one 15-day extension for the review period if the secretary of the department approves the extension. If the department fails to act within the specified time, it shall be deemed to have approved the plans and specifications. When the department disapproves plans and specifications, it shall set forth in writing the reasons for its disapproval. Conferences and consultations may be provided as necessary.

(2)(a) The department is authorized to charge an initial fee of $2,000 for review of plans and construction on all projects, no part of which is refundable. The department may also collect a fee, not to exceed 1 percent of the estimated construction cost or the actual cost of review, whichever is less, for the portion of the review which encompasses initial review through the initial revised construction document review. The department is further authorized to collect its actual costs on all subsequent portions of the review and construction inspections. The initial fee payment shall accompany the initial submission of plans and specifications. Any subsequent payment that is due is payable upon receipt of the invoice from the department.

(b) Notwithstanding any other provisions of law to the contrary, all moneys received by the department pursuant to the provisions of this section shall be *deposited in the Planning and Evaluation Trust Fund* ~~deemed to be trust funds~~, to be held and applied solely for the operations required under this section.

~~(3) When the department determines that a county or municipality is qualified to inspect and review plans and specifications, the department may delegate to that county or municipality the authority to review and approve plans and specifications based upon the statewide standards of the department. The time limits for approval or disapproval of plans and specifications by the department, as established in subsection (1), shall apply to the county or municipality. When such county or municipal approval is authorized in lieu of departmental approval, the fee charged by the department for such services shall be waived.~~

Section 7. Section 395.011, Florida Statutes, is transferred, renumbered as section 395.0191, Florida Statutes, and amended to read:

395.0191 ~~395.011~~ Staff membership and ~~professional~~ clinical privileges.—

(1) No licensed facility, in considering and acting upon an application for staff membership or ~~professional~~ clinical privileges, shall deny the application of a qualified doctor of medicine licensed under chapter 458, a doctor of osteopathy licensed under chapter 459, a doctor of dentistry licensed under chapter 466, ~~or~~ a doctor of podiatry licensed under chapter 461, *or a psychologist licensed under chapter 490* for such staff membership or ~~professional~~ clinical privileges within the scope of his respective licensure solely because the applicant is licensed under any of such chapters.

(2)(a) Each licensed facility shall establish rules and procedures for consideration of an application for clinical privileges submitted by an advanced registered nurse practitioner licensed and certified under chapter 464, in accordance with the provisions of this section. No licensed facility shall deny such application solely because the applicant is licensed under chapter 464 *or because the applicant is not a participant in the Florida Birth-Related Neurological Injury Compensation Plan.*

~~For the purposes of this subsection, the term "clinical privileges" does not include the privilege of admitting patients or the privilege of membership on the medical staff.~~

(b) An advanced registered nurse practitioner who is certified as a registered nurse anesthetist licensed under chapter 464 shall administer anesthesia under the onsite medical direction of a *professional* ~~practitioner~~ licensed under chapter 458, chapter 459, or chapter 466, and in accordance with an established protocol approved by the medical staff. The medical direction shall specifically address the needs of the individual patient.

~~(3)(a) Each licensed facility shall establish rules and procedures for consideration of an application for staff membership and clinical privileges submitted by a psychologist licensed and certified under chapter 490. A licensed facility may not deny such application solely because the applicant is licensed under chapter 490. The accordance and delineation of medical staff membership or clinical privileges shall be determined on an individual basis commensurate with an applicant's education, training, experience, and demonstrated clinical competence.~~

(c)~~(b)~~ Each *hospital* ~~licensed facility~~ shall establish rules and procedures for consideration of an application for clinical privileges submitted by a physician assistant certified pursuant to s. 458.347 or s. 459.022. Clinical privileges granted to a physician assistant pursuant to this subsection shall automatically terminate upon termination of staff membership of the physician assistant's supervising physician. ~~For purposes of this subsection, the term "clinical privileges" does not include the privilege of admitting patients or the privilege of membership on the medical staff.~~

(3)~~(4)~~ When a licensed facility requires, as a precondition to obtaining staff membership or ~~professional~~ clinical privileges, the completion of, eligibility in, or graduation from any program or society established by or relating to the American Medical Association or the Liaison Committee on Graduate Medical Education, the licensed facility shall also make available such membership or privileges to physicians who have attained completion of, eligibility in, or graduation from any equivalent program established by or relating to the American Osteopathic Association.

(4)~~(5)~~ Nothing herein shall restrict in any way the authority of the medical staff of a licensed facility to review for approval or disapproval all applications for appointment and reappointment to all categories of staff and to make recommendations on each applicant to the governing *board* ~~authority~~, including the delineation of privileges to be granted in each case. In making such recommendations and in the delineation of privileges, each applicant shall be considered individually pursuant to criteria for a doctor licensed under chapter 458, chapter 459, chapter 461, or chapter 466, ~~or~~ for an advanced registered nurse practitioner licensed and certified under chapter 464, *or for a psychologist licensed under chapter 490,* as applicable. The applicant's eligibility for staff membership or ~~professional~~ clinical privileges shall be determined by the applicant's background, experience, health, training, and demonstrated competency; the applicant's adherence to applicable professional ethics; the applicant's reputation; and the applicant's ability to work with others and by such other elements as ~~may be~~ determined by the governing board, consistent with this part.

(5)~~(6)~~ The governing *board* ~~body~~ of each licensed facility shall set standards and procedures to be applied by the licensed facility and its medical staff in considering and acting upon applications for staff membership or ~~professional~~ clinical privileges. These standards and procedures shall be available for public inspection.

(6)~~(7)~~ Upon the written request of the applicant, any licensed facility that has denied staff membership or ~~professional~~ clinical privileges to any applicant specified in subsection (1) or subsection (2) shall, within 30 days *after* ~~of~~ such request, provide the applicant with the reasons for such denial in writing. A denial of staff membership or ~~professional~~ clinical privileges to any applicant shall be submitted, in writing, to the applicant's respective licensing board.

(7)~~(8)~~ There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any licensed facility, its governing *board* ~~body~~ or governing *board* ~~body~~ members, medical staff, or disciplinary board or against its agents, investigators, witnesses, or employees, or against any other person, for any action taken in good faith and without intentional fraud in carrying out the provisions of this section.

(8)~~(9)~~ The investigations, proceedings, and records of the board, *or agent thereof with whom there is a specific written contract for that purpose,* as described in this section shall not be subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of matters which are the subject of evaluation and review by such board, and no person who was in attendance at a meeting of such board *or its agent* shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such board *or its agent* or as to any findings, recommendations, evaluations, opinions, or other actions of such board *or its agent* or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such board; nor should any person who testifies before such board or who is a member of such board be prevented from testifying as to matters within his knowledge, but such witness cannot be asked about his testimony before such a board or opinions formed by him as a result of such board hearings.

(9)~~(10)~~(a) *If* ~~In the event that~~ the defendant prevails in an action brought by an applicant against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section, the court shall award reasonable attorney's fees and costs to the defendant.

(b) As a condition of any applicant bringing any action against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section and before any responsive pleading is due, the applicant shall post a bond or other security, as set by the court having jurisdiction of the action, in an amount sufficient to pay the costs and attorney's fees.

(10)~~(11)~~ Nothing herein shall be construed by the department as requiring an applicant for a certificate of need to establish proof of discrimination in the granting of or denial of hospital staff membership or ~~professional~~ clinical privileges as a precondition to obtaining such certificate of need under the provisions of s. 381.713.

Section 8. Section 395.0115, Florida Statutes, is transferred, renumbered as section 395.0193, Florida Statutes, and amended to read:

395.0193 ~~395.0115~~ Licensed facilities; peer review; disciplinary powers.—

(1) It is the intent of the Legislature that good-faith participants in the process of investigating and disciplining physicians pursuant to the state-mandated peer review process shall, in addition to receiving immunity from retaliatory tort suits pursuant to s. 455.225(12), be protected from federal antitrust suits filed under the Sherman Anti-Trust Act, 15 U.S.C.A., s. 1 et seq. Such intent is within the public policy of the state to secure the provision of quality medical services to *the public* ~~its citizens~~.

(2) Each licensed facility, as a condition of licensure, shall provide for peer review of physicians who deliver health care services at the facility. Each *licensed* facility shall develop written, binding procedures by which such peer review shall be conducted. Such procedures shall include:

(a) Mechanism for choosing the membership of the body or bodies that conduct peer review.

(b) Adoption of rules of order for the peer review process.

(c) Fair review of the case with the physician involved.

(d) Mechanism to identify and avoid conflict of interest on the part of the peer review panel members.

(e) Recording of agendas and minutes which do not contain confidential material, for review by the Division of Medical Quality Assurance of the Department of Professional Regulation *and the department.*

(f) Review, at least annually, of the peer review procedures by the governing board of the *licensed* facility.

(g) Focus of the peer review process on review of professional practices at the facility to reduce morbidity and mortality and to improve patient care.

(3) If reasonable belief exists that conduct by a staff member or physician who delivers health care services at the *licensed* facility may con-

stitute one or more grounds for discipline as provided in this subsection, a peer review panel shall investigate and determine whether grounds for discipline exist with respect to such staff member or physician. The governing board of any licensed facility, after considering the recommendations of its peer review panel, shall suspend, deny, revoke, or curtail the privileges, or reprimand, counsel, or require education, of any such staff member or physician after a final determination has been made that one or more of the following grounds exist:

(a) Incompetence.

(b) Being found to be a habitual user of intoxicants or drugs to the extent that he is deemed dangerous to himself or others.

(c) Mental or physical impairment which may adversely affect patient care.

(d) Being found liable by a court of competent jurisdiction for medical negligence or malpractice involving negligent conduct.

(e) One or more settlements exceeding $10,000 for medical negligence or malpractice involving negligent conduct by the staff member.

(f) Medical negligence other than as specified in paragraphs (d) or (e).

(g) Failure to comply with the policies, procedures, or directives of the risk management program or any quality assurance committees of any licensed facility.

However, the procedures for such actions shall comply with the standards outlined by the Joint Commission on Accreditation of *Healthcare Organizations* ~~Hospitals~~, the American Osteopathic Association, *the Commission on Association of Rehabilitation Facilities,* the Accreditation Association for Ambulatory Health Care, *Inc.*, ~~and~~ the "Medicare/Medicaid Conditions of Participation," *and the rules of the department* ~~as such procedures existed on January 1, 1985~~. The procedures shall be adopted pursuant to hospital bylaws.

(4) All final disciplinary actions taken under subsection (3) shall be reported within 10 working days to the Division of Medical Quality Assurance *of the Department of Professional Regulation and to the department* in writing and shall specify the disciplinary action taken and the specific grounds therefor. The division shall *review* ~~treat~~ each report and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case ~~the provisions of~~ s. 455.225 shall apply. The report shall not be subject to inspection under ~~the provisions of~~ s. 119.07(1) even if the division's investigation results in a finding of probable cause. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(5) There shall be no monetary liability on the part of, and no cause of action for damages ~~shall arise~~ against, any licensed facility, its governing *board* ~~body~~ *or* ~~and~~ governing *board* ~~body~~ members, peer review panel, medical staff, or disciplinary body, or its agents, investigators, witnesses, employees, or any other person for any action taken without intentional fraud in carrying out the provisions of this section.

(6) The proceedings and records of peer review panels, committees, and governing *boards or agents thereof* ~~bodies~~ which relate solely to actions taken in carrying out ~~the provisions of~~ this section *are not* ~~shall not under any circumstances be~~ subject to inspection under ~~the provisions of~~ s. 119.07(1); *and* ~~nor shall~~ meetings held pursuant to achieving the objectives of such panels, committees, and governing *boards are not* ~~bodies be~~ open to the public under the provisions of chapter 286. The exemptions provided by this subsection are subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(7) The investigations, proceedings, and records of *a peer review panel, a committee, a disciplinary board, or a governing* ~~the~~ board *or agent thereof* as described in this section shall not be subject to discovery or introduction into evidence in any civil or administrative action against a provider of professional health services arising out of the matters which are the subject of evaluation and review by such *group or its agent;* ~~board,~~ and *a* ~~no~~ person who was in attendance at a meeting of such *group or its agent may not* ~~board shall~~ be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or presented during the proceedings of such *group or its agent* ~~board~~ or as to any findings, recommendations, evaluations, opinions, or other actions of such *group or its agent* ~~board~~ or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil or administrative action merely because they were presented during proceedings of such *group; and* ~~board; nor should~~ any person who testifies before such *group* ~~board~~ or who is a member of such *group may not* ~~board~~ be prevented from testifying as to matters within his knowledge, but such witness *may not* ~~cannot~~ be asked about his testimony before such a *group* ~~board~~ or opinions formed by him as a result of such *group* ~~board~~ hearings.

(8)(a) *If* ~~In the event that~~ the defendant prevails in an action brought by a staff member or physician who delivers health care services at the *licensed* facility against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section, the court shall award reasonable attorney's fees and costs to the defendant.

(b) As a condition of any staff member or physician bringing any action against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section and before any responsive pleading is due, the staff member or physician shall post a bond or other security, as set by the court having jurisdiction of the action, in an amount sufficient to pay the costs and attorney's fees.

(9)(a) A hospital's compliance with the requirements of this chapter or s. 766.110(1) may not be the sole basis for establishing an agency or partnership relationship between the hospital and physicians who provide services within that hospital.

(b) A hospital may establish an agency relationship with a physician by written contract signed by the hospital and:

1. The physician;

2. A health care professional association; or

3. A corporate medical group and its employees.

A written contract is not the exclusive means to establish an agency or partnership relationship between a hospital and any other person described in this paragraph.

Section 9. Section 395.014, Florida Statutes, is transferred, renumbered as section 395.0195, Florida Statutes, and amended to read:

395.0195 ~~395.014~~ Access of chiropractors to diagnostic reports.—Each hospital shall set standards and procedures which provide for reasonable access by licensed chiropractors to the reports of diagnostic X rays and laboratory tests of *licensed facilities* ~~institutions licensed pursuant to this part~~, subject to the same standards and procedures as other licensed physicians. However, ~~nothing contained in the provisions of~~ this section *does not* ~~shall~~ require a licensed facility to grant staff privileges to a chiropractor.

Section 10. Section 395.041, Florida Statutes, is transferred, renumbered as section 395.0197, Florida Statutes, and amended to read:

395.0197 ~~395.041~~ Internal risk management program.—

(1) Every *licensed* facility ~~licensed under this chapter~~ shall, as a part of its administrative functions, establish an internal risk management program which shall include the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients;

(b) The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, including risk management and risk prevention education and training of all nonphysician personnel as follows:

1. Such education and training of all nonphysician personnel as part of their initial orientation; and

2. At least 1 hour of such education and training annually for all nonphysician personnel of the *licensed* facility working in clinical areas and providing patient care;

(c) The analysis of patient grievances which relate to patient care and the quality of medical services; and

(d) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the *licensed* health care facility to report ~~injuries and~~ adverse incidents to the hospital risk manager.

(2) The *internal* risk management program *is* ~~shall be~~ the responsibility of the governing board of the health care facility. *Each licensed facility* ~~As of October 1, 1986, every facility licensed under this chapter~~ shall hire a risk manager, *licensed* ~~certified~~ under part IX of chapter 626, who *is* ~~shall be~~ responsible for implementation and oversight of such facility's *internal* risk management program as required by this section. *A risk manager must not be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals.* ~~Part-time risk managers shall not be responsible for risk management programs in more than four such facilities.~~

(3) In addition to the programs mandated by this *section* ~~act~~, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims shall be encouraged and their implementation and operation facilitated. Such additional approaches may include extending *internal* risk management programs to health care providers' offices and the assuming of provider liability by a *licensed* health care facility for acts or omissions occurring within the *licensed* facility.

(4) The department ~~of Health and Rehabilitative Services~~ shall, after consulting with the Department of Insurance, *adopt* ~~promulgate~~ rules governing the establishment of such internal risk management programs to meet the needs of individual *licensed facilities* ~~establishments~~. ~~The Department of Insurance shall assist the Department of Health and Rehabilitative Services in preparing such rules.~~ Each internal risk management program shall include the use of incident reports to be filed with an individual of responsibility who is competent in risk management techniques in the employ of each *licensed facility* ~~establishment~~, such as an insurance coordinator, or who is retained by *the licensed facility* ~~said establishment~~ as a consultant. *The* ~~Said~~ individual *responsible for the risk management program* shall have free access to all ~~establishment~~ medical records *of the licensed facility*~~, and the rules promulgated by the Department of Health and Rehabilitative Services shall so provide~~. The incident reports *are* ~~shall be considered to be a~~ part of the workpapers of the attorney defending the *licensed facility* ~~establishment~~ in litigation relating *to the licensed facility and are* ~~thereto and shall be~~ subject to discovery, but *are not* ~~shall not be~~ admissible as evidence in court. *A*~~, nor shall any~~ person filing an incident report *is not* ~~be~~ subject to civil suit by virtue of such incident report. As a part of each internal risk management program, the incident reports shall be *used* ~~utilized~~ to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct *the* ~~said~~ problem areas.

(5)(a) Each licensed facility subject to this section shall submit *an annual* ~~a quarterly~~ report to the department summarizing the incident reports that have been filed in the facility for that *year* ~~quarter~~. The report ~~shall be on a form prescribed by rule of the department and~~ shall include:

1. The total number of adverse incidents causing injury to patients.

2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries, and the number of incidents occurring within each category.

3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.

4. A code number *using* ~~utilizing~~ the health care professional's licensure number and a separate code number identifying all other individuals directly involved in adverse incidents causing injury to patients, the relationship of the individual to the *licensed* facility, and the number of incidents in which each individual has been directly involved. Each *licensed* facility shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.

5. A description of all malpractice claims filed against the *licensed* facility, including the total number of pending and closed claims and the nature of the incident which led to, the persons involved in, and the status and disposition of each claim. Each report shall update status and disposition for all prior reports.

6. A report of all disciplinary actions pertaining to patient care taken against any medical staff member, including the nature and cause of the action.

(b) The information reported to the department pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall also be reported to the Department of Professional Regulation *annually* ~~on a quarterly basis~~. The Department of Professional Regulation shall review the information and determine whether any of the incidents potentially involved conduct by a *health care professional* licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(c) The report submitted to the department shall also contain the name *and license number* of the risk manager of the *licensed* facility, a copy of its policy and procedures which govern the measures taken by the facility and its risk manager to reduce the risk of injuries and adverse or untoward incidents, and the results of such measures. The *annual report is* ~~quarterly reports shall be held~~ confidential and *is not* ~~shall not be~~ available to the public pursuant to s. 119.07(1) or any other law providing access to public records. *The annual report is not*~~, nor be~~ discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the department, the Department of Professional Regulation, and the appropriate regulatory board *of the Department of Professional Regulation.* The *annual report is not* ~~quarterly reports shall not be~~ available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department, the Department of Professional Regulation, or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a *health care professional* ~~practitioner~~ against whom probable cause has been found, any such records which form the basis of the determination of probable cause.

(6) If an adverse or untoward incident, whether occurring in the *licensed* facility or arising from health care prior to admission in the *licensed* facility, results in:

(a) The death of a patient;

(b) ~~Severe~~ Brain or spinal damage to a patient;

(c) *The performance of* a surgical procedure ~~being performed~~ on the wrong patient; or

(d) A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient, *including the surgical repair of injuries or damage resulting from the planned surgical procedure, wrong site or wrong procedure surgeries, and procedures to remove foreign objects remaining from surgical procedures,*

the *licensed* facility shall report this incident to *both* the department *and the Department of Professional Regulation* within 15 calendar days *after* ~~of~~ its occurrence. *Either* ~~The~~ department may require an additional, final report. ~~Reports under this subsection shall be sent immediately by the department to the Department of Professional Regulation whenever they involve a health care provider licensed under chapter 458, chapter 459, chapter 461, or chapter 466.~~ These reports shall not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the department, the Department of Professional Regulation, and the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board *of the Department of Professional Regulation.* However, the Department of Professional Regulation shall make available, upon written request by a *health care professional* ~~practitioner~~ against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The department may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The Department of Professional Regulation shall review each incident and determine whether it potentially involved conduct by the *health care professional* ~~licensee~~ that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(7) In addition to any penalty imposed pursuant to *this section* ~~s. 395.018~~, the department may impose an administrative fine, not to exceed $5,000, for any violation of the reporting requirements of *this section* ~~subsection (5) or subsection (6)~~. ~~This subsection shall take effect July 1, 1989.~~

(8) The department and, upon subpoena issued pursuant to s. 455.223, the Department of Professional Regulation shall have access to all *licensed* facility records necessary to carry out the provisions of this section. The records obtained are not available to the public under s. 119.07(1), nor shall they be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the department, the Department of Professional Regulation, and the appropriate regulatory board *of the Department of Professional Regulation*, nor shall records obtained pursuant to s. 455.223 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board *of the Department of Professional Regulation*. However, the Department of Professional Regulation shall make available, upon written request by a *professional* ~~practitioner~~ against whom probable cause has been found, any such records which form the basis of the determination of probable cause, except that, with respect to medical review committee records, ~~the provisions of~~ s. 766.101 *controls* ~~shall control~~.

(9) The meetings of the committees and governing board of a licensed facility held solely for the purpose of achieving the objectives of risk management as provided by this section shall not be open to the public under the provisions of chapter 286. The records of such meetings are confidential and exempt from ~~the provisions of~~ s. 119.07(1), except as provided in subsection (8).

(10) The department shall review, *as part of its licensure inspection process* ~~no less than annually~~, the *internal* risk management program at each facility regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents under subsections (5) and (6).

(11) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager, *licensed* ~~certified~~ under part IX of chapter 626, for the implementation and oversight of the *internal* risk management program a facility licensed under this chapter or chapter 390 as required by this section, for any act or proceeding undertaken or performed within the scope of the functions of such *internal* risk management program if the risk manager acts without intentional fraud.

(12) If the department, through its receipt of the annual reports prescribed in subsection (5) or through any investigation, has a reasonable belief that conduct by a staff member or employee of a *licensed* facility *constitutes* ~~may constitute~~ grounds for disciplinary action by the appropriate regulatory board *of the Department of Professional Regulation*, the department shall report this fact to such regulatory board.

(13) The department shall annually publish a report summarizing the information contained in the annual incident reports submitted by licensed facilities and any serious incident reports submitted by licensed facilities. The report must, at a minimum, summarize:

(a) Adverse and serious incidents, by district of the department, by category of reported incident, and by type of professional involved.

(b) Types of malpractice claims filed, by district of the department and by type of professional involved.

(c) Disciplinary actions taken against professionals, by district of the department and by type of professional involved.

~~(13) The department shall send information bulletins to all facilities as necessary to disseminate trends and preventive data derived from its actions under this section. The gross data compiled shall be furnished by the department upon request to facilities to be utilized for risk management purposes.~~

~~(14) The department may promulgate rules necessary to carry out the provisions of this section.~~

(14)~~(15)~~ The exemptions from s. 119.07(1) and chapter 286 provided by paragraph (5)(c) and subsections (6), (8), and (9) are subject to the Open Government Sunset Review Act in accordance with s. 119.14.

Section 11. Section 395.0172, Florida Statutes, is transferred, renumbered as section 395.0199, Florida Statutes, and amended to read:

395.0199 ~~395.0172~~ Private utilization review.—

(1) The purpose of this section is to:

(a) Promote the delivery of quality health care in a cost-effective manner.

(b) Foster greater coordination between providers and health insurers performing utilization review.

(c) Protect patients and insurance providers by ensuring that private review agents are qualified to perform utilization review activities and to make informed decisions on the appropriateness of medical care.

(d) This section *does not* ~~shall not be construed to~~ regulate the activities of private review agents, health insurers, health maintenance organizations, or hospitals, except as expressly provided *in this section* ~~herein~~, or ~~to~~ authorize regulation or intervention as to the correctness of utilization review decisions of insurers or private review agents.

~~(2) As used in this section, the term:~~

~~(a) "Department" means the Department of Health and Rehabilitative Services.~~

~~(b) "Initial denial determination" means a determination by a private review agent that the health care services furnished or proposed to be furnished to a patient are inappropriate, not medically necessary, or not reasonable.~~

~~(c) "Private review agent" means any person or entity which performs utilization review services for third-party payors on a contractual basis for outpatient or inpatient services. However, the term shall not include full-time employees, personnel, or staff of health insurers, health maintenance organizations, or hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, when performing utilization review for their respective hospitals, health maintenance organizations, or insureds of the same insurance group. For this purpose, health insurers, health maintenance organizations, and hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, include such entities engaged as administrators of self-insurance as defined in s. 624.031.~~

~~(d) "Utilization review" means a system for reviewing the medical necessity or appropriateness in the allocation of health care resources of hospital services given or proposed to be given to a patient or group of patients.~~

~~(e) "Utilization review plan" means a description of the policies and procedures governing utilization review activities performed by a private review agent.~~

(2)~~(3)~~ A private review agent conducting utilization review as to health care services performed or proposed to be performed in this state shall register with the department in accordance with this section.

(3)~~(4)~~ Registration shall be made annually with the department on forms furnished by the department and shall be accompanied by the appropriate registration fee as set by the department. The fee shall be sufficient to pay for the administrative costs of registering the agent, but shall not exceed $250. The department may also charge reasonable fees, reflecting actual costs, to persons requesting copies of registration.

(4)~~(5)~~ Registration shall include the following:

(a) A description of the review policies and procedures to be used in evaluating proposed or delivered hospital care.

(b) The name, address, and telephone number of the utilization review agent performing utilization review, who shall be at least:

1. A licensed practical nurse or licensed registered nurse, or other similarly qualified medical records or health care professionals, for performing initial review when information is necessary from the physician or hospital to determine the medical necessity or appropriateness of hospital services; *or* ~~and~~

2. A licensed physician, or a licensed physician practicing in the field of psychiatry for review of mental health services, for an initial denial determination prior to a final denial determination by the health insurer and which shall include the written evaluation and findings of the reviewing physician.

(c) A description of an appeal procedure for patients or health care providers whose services are under review, who may appeal an initial denial determination prior to a final determination by the health insurer

with whom the private review agent has contracted. The appeal procedure shall provide for review by a licensed physician, or by a licensed physician practicing in the field of psychiatry for review of mental health services, and shall include the written evaluation and findings of the reviewing physician.

(d) A designation of the times when the staff of the utilization review agent will be available by toll-free telephone, which shall include at least 40 hours per week during the normal business hours of the agent.

(e) An acknowledgment and agreement that any private review agent which, as a general business practice, fails to adhere to the policies, procedures, and representations made in its application for registration shall have its registration revoked.

(f) Disclosure of any incentive payment provision or quota provision which is contained in the agent's contract with a health insurer and is based on reduction or denial of services, reduction of length of stay, or selection of treatment setting.

(g) Updates of any material changes to review policies or procedures.

(5)~~(6)~~ The department may impose fines or suspend or revoke the registration of any private review agent in violation of this section. Any private review agent failing to register or update registration as required by this section shall be deemed to be within the jurisdiction of the department and subject to an administrative penalty not to exceed $1,000. The department may bring actions to enjoin activities of private review agents in violation of this section.

(6)~~(7)~~ No insurer shall knowingly contract with or utilize a private review agent *that* ~~which~~ has failed to register as required by this section or *that* ~~which~~ has had a registration revoked by the department.

(7)~~(8)~~ A private review agent which operates under contract with the federal or state government for utilization review of patients eligible for hospital or other services under Title XVIII or Title XIX of the Social Security Act is exempt from the provisions of this section for services provided under such contract. A private review agent which provides utilization review services to the federal or state government and a private insurer shall not be exempt for services provided to nonfederally funded patients. This section shall not apply to persons who perform utilization review services for medically necessary hospital services provided to injured workers pursuant to chapter 440 and shall not apply to self-insurance funds or service companies authorized pursuant to chapter 440 or part VII of chapter 626.

(8)~~(9)~~ *Facilities* ~~Hospitals~~ licensed under this chapter shall promptly comply with the requests of utilization review agents or insurers which are reasonably necessary to facilitate prompt accomplishment of utilization review activities.

(9) The department shall adopt rules to implement the provisions of this section.

Section 12. Section 395.0101, Florida Statutes, is transferred, renumbered as section 395.1011, Florida Statutes, and amended to read:

395.1011 ~~395.0101~~ Identification, segregation, and separation of *biomedical* ~~biohazardous~~ waste.—Each *licensed facility shall comply with the requirements contained in s. 381.0098.* ~~hospital and ambulatory surgical center shall ensure that biohazardous waste is properly identified, segregated, and separated from other solid waste at the generating facility.~~ Any transporter or potential transporter of such waste shall be notified of the existence and locations of such waste.

Section 13. Section 395.0201, Florida Statutes, is transferred, renumbered as section 395.1021, Florida Statutes, and amended to read:

395.1021 ~~395.0201~~ Treatment of sexual assault victims.—Any licensed facility ~~under this part~~ which provides emergency room services *shall* ~~may~~ arrange for the rendering of appropriate medical attention and treatment of victims of sexual assault through:

(1) Such gynecological, psychological, and medical services as are needed by the victim.

(2) The administration of medical examinations, tests, and analyses required by law enforcement personnel in the gathering of evidence required for investigation and prosecution.

(3) The training of medical support personnel competent to provide the medical services and treatment as described in subsections (1) and (2).

Such licensed facility *shall* ~~may~~ also arrange for the protection of the victim's anonymity while complying with the laws of this state and may encourage the victim to notify law enforcement personnel and to cooperate with them in apprehending the suspect.

Section 14. Section 395.0205, Florida Statutes, is transferred, renumbered as section 395.1023, Florida Statutes, and amended to read:

395.1023 ~~395.0205~~ Child abuse and neglect cases; duties.—*Each licensed facility shall* ~~The department shall, by March 1, 1985, promulgate a rule requiring every general hospital and appropriate specialty hospital, as defined by s. 395.002(4) and (14), to~~ adopt a protocol that, at a minimum, requires *the facility* ~~each hospital administration~~ to:

(1) Incorporate ~~in hospital policy~~ a *facility* policy that every staff member has an affirmative duty to report, pursuant to chapter 415, any actual or suspected case of child abuse or neglect; and

(2) In any case involving suspected child abuse or neglect, designate, at the request of the department, a staff physician to act as a liaison between the hospital and the department office which is investigating the suspected abuse or neglect, and the child protection team, as defined in s. 415.503, when the case is referred to such a team.

Each general hospital and appropriate specialty hospital shall comply with the provisions of this section and shall notify the department of its compliance by sending a copy of its policy to the department *as required by rule* ~~by March 1, 1985~~. The failure by a general hospital or appropriate specialty hospital to comply shall be punished by a fine not exceeding $1,000, to be fixed,imposed, and collected by the department. Each day in violation is considered a separate offense.

Section 15. Section 395.0147, Florida Statutes, is transferred and renumbered as section 395.1025, Florida Statutes.

Section 16. Section 395.038, Florida Statutes, is transferred, renumbered as section 395.1027, Florida Statutes, and amended to read:

395.1027 ~~395.038~~ Regional poison control centers.—

(1) There shall be created three accredited regional poison control centers, one each in the north, central, and southern regions of the state. Each regional poison control center shall be affiliated and physically located in a certified level I trauma center. Each regional poison control center shall be affiliated with an accredited medical school or college of pharmacy. The regional poison control centers shall be coordinated under the aegis of the Children's Medical Services Program Office in the department ~~of Health and Rehabilitative Services~~.

(2) Each regional poison control center shall provide the following services:

(a) Toll-free access by the public for poison information.

(b) Case management of poison cases.

(c) Professional consultation to health care practitioners.

(d) Prevention education to the public.

(e) Data collection and reporting.

Section 17. Section 395.103, Florida Statutes, is created to read:

395.103 Emergency medical services; communication.—Each licensed hospital with an emergency department must be capable of communicating by two-way radio with all ground-based basic life support service vehicles and advanced life support service vehicles that operate within the hospital's service area under a state permit and with all rotorcraft air ambulances that operate under a state permit. The hospital's radio system must be capable of interfacing with municipal mutual aid channels designated by the Division of Communications of the Department of General Services and the Federal Communications Commission.

Section 18. Effective upon this act becoming a law, section 395.0142, Florida Statutes, is amended to read:

395.0142 Access to emergency services and care.—

(1) LEGISLATIVE INTENT.—The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals to every person in need of such care. The Legislature finds that persons have been denied emergency services and care by hospitals. It is the intent of the Legislature that the department vigorously enforce the ability of persons to receive emergency services and care and that the department act in a thorough and timely manner against hospitals which deny persons emergency services and care.

(2) DEFINITIONS.—As used in this section:

(a) "Active labor" means a labor at a time at which:

1. There is inadequate time to effect safe transfer to another hospital prior to delivery; or

2. A transfer may pose a threat to the health and safety of the patient or the unborn child.

(b) "Department" means the Department of Health and Rehabilitative Services.

(c) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the patient's health.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(d) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

(e) "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the patient from a hospital.

(3) INVENTORY OF HOSPITAL EMERGENCY SERVICES.—The department shall establish and maintain an inventory of hospitals with emergency services. The inventory must list all services within the service capability of the hospital, and such services must appear on the face of the hospital license. Each hospital having emergency services shall notify the department of its service capability in the manner and form prescribed by the department. The department shall use the inventory to assist emergency medical services providers and others in locating appropriate emergency medical care. The inventory shall also be made available to the public. On or before May 1, 1992, the department shall request that each hospital identify the services that are within its service capability. On or before August 1, 1992, the department shall notify each hospital of the service capability to be included in the inventory. The hospital has 15 days from the date of receipt within which to respond to the notice. By September 1, 1992, the department shall publish a final inventory. Each hospital shall reaffirm its service capability when its license is renewed and shall notify the department of the addition of a new service or the termination of a service prior to a change in its service capability.

(4)~~(3)~~ EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(a) Every hospital which has an emergency department shall provide emergency services and care for any emergency medical condition or for active labor when:

1. Any person requests emergency services and care; or

2. Emergency services and care are requested on behalf of a person by:

a. An emergency medical services provider who is rendering care to or transporting the person; or

b. Another hospital, when such hospital is seeking a medically necessary transfer for a patient who has been stabilized, when such transfer meets the requirements of s. 395.0144 and applicable federal law.

(b)1. Except as provided in subparagraph 4., every hospital shall ensure the provision of services within the service capability of the hospital, at all times, either directly or indirectly through an arrangement with another hospital, through an arrangement with one or more physicians, or as otherwise made through prior arrangement. A hospital may enter into an agreement with another hospital for purposes of meeting its service capability requirement, and appropriate compensation or other reasonable conditions may be negotiated for these backup services.

2. If any arrangement requires the provision of emergency medical transportation, such arrangement must be made in consultation with the applicable provider and may not require the emergency medical service provider to provide transportation that is outside the routine service area of that provider or in a manner that impairs the ability of the emergency medical service provider to respond timely to prehospital emergency calls.

3. The department may exempt a hospital from ensuring service capability at all times as required by subparagraph 1. if, prior to the receiving of patients needing such service capability, the hospital demonstrates to the department that it lacks the ability to ensure such capability and that it has exhausted all reasonable efforts to ensure such capability through backup arrangements. In reviewing a hospital's demonstration of lack of ability to ensure service capability, the department shall consider factors relevant to the particular case, including any of the following:

a. Number and proximity of hospitals having the same service capability.

b. Number, type, credentials, and privileges of specialists.

c. Frequency of procedures.

d. Size of hospital.

4. The department shall publish proposed rules implementing a reasonable exemption procedure by August 1, 1992. Subparagraph 1. shall become effective upon the effective date of the rules or January 1, 1993, whichever is earlier. For a period not to exceed 1 year from the effective date of subparagraph 1., a hospital requesting an exemption is deemed to be exempt from offering the service until the department initially acts to deny or grant the original request. The department has 45 days after the date of receipt of the request within which to approve or deny the request. After the first year from the effective date of subparagraph 1., if the department fails to initiate action within the time period, the hospital is deemed to be exempt from offering the service until the department initially acts.

(c)~~(b)~~ In no event shall the provision of emergency services and care be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(d)~~(c)~~ Neither the hospital nor its employees, nor any physician, dentist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, that the person is not in active labor, or that the hospital does not have the appropriate facilities or qualified personnel available to render those services.

(e)~~(d)~~ Emergency services and care shall be rendered without first questioning the patient or any other person as to his or her ability to pay therefor. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital to guarantee payment for the person as a condition of receiving transfer. However, the patient or his or her legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly after the services and care are rendered.

(f)~~(e)~~ If a hospital subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency medical condition exists and, in addition to meeting the requirements of s. 395.0143,

shall direct the persons seeking emergency care to a nearby facility which can render the needed services and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(5)~~(4)~~ RECORDS OF TRANSFERS; REPORT OF VIOLATIONS.—

(a) Each hospital shall maintain records of each transfer made or received for a period of 3 years.

(b) Any hospital employee, physician, other licensed emergency room health care personnel, or certified prehospital emergency personnel who knows of an apparent violation of this section or the rules adopted hereunder shall report the apparent violation to the department on a form prescribed by the department within 1 week following its occurrence.

(c) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to, a physician or other personnel for reporting in good faith an apparent violation of this section or the rules adopted hereunder to the department, hospital, medical staff, or any other interested party or government agency.

(d) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to, a physician who refused to transfer a patient when the physician determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the person.

(6)~~(5)~~ PENALTIES.—

(a) The department may deny, revoke, or suspend a license or impose an administrative fine, not to exceed $10,000 per violation, for the violation of any provision of this section or rules adopted hereunder.

(b) Any person who suffers personal harm as a result of a violation of this section or the rules adopted hereunder may recover, in a civil action against the responsible administrative or medical personnel, damages, reasonable attorney's fees, and other appropriate relief. *However, this paragraph does not create a cause of action beyond that recognized by this section and rules adopted under this section as they existed on April 1, 1992.*

(c) Any administrative or medical personnel who knowingly or intentionally violates any provision of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(7)~~(6)~~ RIGHTS OF PERSONS BEING TREATED.—A person who is being involuntarily examined under the provisions of s. 394.463(2)(a) and is being evaluated or treated at a hospital for an emergency medical condition shall be afforded the rights of patients specified in s. 394.459. These rights shall be afforded to the person regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under chapter 394, and regardless of whether the person is admitted. The patient must be examined under s. 394.463(2)(c) within 72 hours. The 72-hour detainment period specified in s. 394.463 begins when the patient arrives at the hospital, ceases when the attending physician documents that the patient has an emergency medical condition, and resumes after a physician documents that the patient is stabilized and that the emergency condition is alleviated. If the hospital is not a receiving facility designated under chapter 394, one of the following must occur within 12 hours after the physician documents that the patient's emergency medical condition has stabilized and appropriate medical treatment is available at the designated receiving facility to which the patient is being transferred or that an emergency medical condition does not exist:

(a) The patient must be evaluated by a designated receiving facility and released; or

(b) The patient must be transferred to a designated receiving facility.

Section 19. Section 395.0142, Florida Statutes, is transferred, renumbered as section 395.1041, Florida Statutes, and amended to read:

395.1041 ~~395.0142~~ Access to emergency services and care.—

(1) LEGISLATIVE INTENT.—The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals *and physicians* to every person in need of such care. The Legislature finds that persons have been denied emergency services and care by hospitals. It is the intent of the Legislature that the department vigorously enforce the ability of persons to receive *all necessary and appropriate* emergency services and care and that the department act in a thorough and timely manner against hospitals *and physicians* which deny persons emergency services and care. *It is further the intent of the Legislature that hospitals, emergency medical services providers, and other health care providers work together in their local communities to enter into agreements or arrangements to ensure access to emergency services and care. The Legislature further recognizes that appropriate emergency services and care often require followup consultation and treatment in order to effectively care for emergency medical conditions.*

~~(2) DEFINITIONS.—As used in this section:~~

~~(a) "Active labor" means a labor at a time at which:~~

~~1. There is inadequate time to effect safe transfer to another hospital prior to delivery; or~~

~~2. A transfer may pose a threat to the health and safety of the patient or the unborn child.~~

~~(b) "Department" means the Department of Health and Rehabilitative Services.~~

~~(c) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:~~

~~1. Serious jeopardy to the patient's health.~~

~~2. Serious impairment to bodily functions.~~

~~3. Serious dysfunction of any bodily organ or part.~~

~~(d) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.~~

~~(e) "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the patient from a hospital.~~

(2)~~(3)~~ INVENTORY OF HOSPITAL EMERGENCY SERVICES.—The department shall establish and maintain an inventory of hospitals with emergency services. The inventory must list all services within the service capability of the hospital, and such services must appear on the face of the hospital license. Each hospital having emergency services shall notify the department of its service capability in the manner and form prescribed by the department. The department shall use the inventory to assist emergency medical services providers and others in locating appropriate emergency medical care. The inventory shall also be made available to the public. On or before May 1, 1992, the department shall request that each hospital identify the services that are within its service capability. On or before August 1, 1992, the department shall notify each hospital of the service capability to be included in the inventory. The hospital has 15 days from the date of receipt within which to respond to the notice. By September 1, 1992, the department shall publish a final inventory. Each hospital shall reaffirm its service capability when its license is renewed and shall notify the department of the addition of a new service or the termination of a service prior to a change in its service capability.

(3)~~(4)~~ EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(a) Every *general* hospital which has an emergency department shall provide emergency services and care for any emergency medical condition ~~or for active labor~~ when:

1. Any person requests emergency services and care; or

2. Emergency services and care are requested on behalf of a person by:

a. An emergency medical services provider who is rendering care to or transporting the person; or

b. Another hospital, when such hospital is seeking a medically necessary transfer, *except as otherwise provided in this section* ~~for a patient who has been stabilized, when such transfer meets the requirements of s. 395.0144 and applicable federal law~~.

(b) Arrangements for transfers must be made between hospital emergency services personnel for each hospital, unless other arrangements between the hospitals exist.

(c) A patient, whether stabilized or not, may be transferred to another hospital that has the requisite service capability or is not at service capacity, if:

1. The patient, or a person who is legally responsible for the patient and acting on the patient's behalf, after being informed of the hospital's obligation under this section and of the risk of transfer, requests that the transfer be effected;

2. A physician has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital outweigh the increased risks to the individual's medical condition from effecting the transfer; or

3. A physician is not physically present in the emergency services area at the time an individual is transferred and a qualified medical person signs a certification that a physician, in consultation with personnel, has determined that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer. The consulting physician must countersign the certification;

However, this paragraph does not require acceptance of a transfer that is not medically necessary.

(d) ~~(b)~~1. *Except* ~~Effective~~ as provided in subparagraph 4., every hospital shall ensure the provision of services within the service capability of the hospital, at all times, either directly or indirectly through an arrangement with another hospital, through an arrangement with one or more physicians, or as otherwise made through prior arrangement. A hospital may enter into an agreement with another hospital for purposes of meeting its service capability requirement, and appropriate compensation or other reasonable conditions may be negotiated for these backup services.

2. If any arrangement requires the provision of emergency medical transportation, such arrangement must be made in consultation with the applicable provider and may not require the emergency medical service provider to provide transportation that is outside the routine service area of that provider or in a manner that impairs the ability of the emergency medical service provider to respond timely to prehospital emergency calls.

3. The department may exempt a hospital from ensuring service capability at all times as required by subparagraph 1. if, prior to the receiving of patients needing such service capability, the hospital demonstrates to the department that it lacks the ability to ensure such capability and that it has exhausted all reasonable efforts to ensure such capability through backup arrangements. In reviewing a hospital's demonstration of lack of ability to ensure service capability, the department shall consider factors relevant to the particular case, including any of the following:

a. Number and proximity of hospitals having the same service capability.

b. Number, type, credentials, and privileges of specialists.

c. Frequency of procedures.

d. Size of hospital.

4. The department shall publish proposed rules implementing a reasonable exemption procedure by August 1, 1992. Subparagraph 1. shall become effective upon the effective date of the rules or January 1, 1993, whichever is earlier. For a period not to exceed 1 year from the effective date of subparagraph 1., a hospital requesting an exemption is deemed to be exempt from offering the service until the department initially acts to deny or grant the original request. The department has 45 days after the date of receipt of the request within which to approve or deny the request. After the first year from the effective date of subparagraph 1., if the department fails to initiate action within the time period, the hospital is deemed to be exempt from offering the service until the department initially acts.

(e) Except as otherwise provided by law, a medically necessary transfer must be made to the geographically closest hospital having the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. If the condition of the transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(f) ~~(c)~~ In no event shall the provision of emergency services and care, *the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e)* be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(g) ~~(d)~~ Neither the hospital nor its employees, nor any physician, dentist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is *made after screening, examining, and evaluating the patient and is* based on *a* ~~the~~ determination, exercising reasonable care, that the person is not suffering from an emergency medical condition~~, that the person is not in active labor,~~ or *a determination, exercising reasonable care,* that the hospital does not have the *service capability or is at service capacity* ~~appropriate facilities or qualified personnel available~~ to render those services.

(h) ~~(e)~~ Emergency services and care shall be rendered without first questioning the patient or any other person as to *the patient's* ~~his or her~~ ability to pay *for the emergency services and care* ~~therefor~~. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital *or any person or entity* to guarantee payment for the person as a condition of receiving *the* transfer. *In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred.* However, the patient or *the patient's* ~~his or her~~ legally responsible relative or guardian shall execute an agreement to pay *for emergency services or care* ~~therefor~~ or otherwise supply insurance or credit information promptly after the services and care are rendered.

(i) Each hospital offering emergency services shall post, in a conspicuous place in the emergency service area, a sign clearly stating a patient's right to emergency services and care and the service capability of the hospital.

(j) ~~(f)~~ If a hospital subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency medical condition exists and~~, in addition to meeting the requirements of s. 395.0143,~~ shall direct the persons seeking emergency care to a nearby facility which can render the needed services and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(k)1. An emergency medical services provider may not condition the prehospital transport of any person in need of emergency services and care on the person's ability to pay. Nor may an emergency medical services provider condition a transfer on the person's ability to pay if the transfer is necessary because the patient is in immediate need of treatment for an emergency medical condition for which the hospital lacks service capability or if the hospital is at service capacity. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for the transport or otherwise supply insurance or credit information promptly after the transport is rendered.

2. A hospital may enter into an agreement with an emergency medical services provider for purposes of meeting its service capability requirements, and appropriate compensation and other reasonable conditions may be negotiated for those services.

(4) ~~(5)~~ RECORDS OF TRANSFERS; REPORT OF VIOLATIONS.—

(a)*1.* Each hospital shall maintain records of each transfer made or received for a period of ~~5~~ 3 years. *The records of each transfer must be included in a transfer log, as well as in the permanent medical record of the patient who is transferred or received.*

2. Each hospital shall maintain records of each patient who requests emergency care and services, or person on whose behalf emergency care and services are requested, for a period of 5 years. The records must be included in a log, as well as in the permanent medical record of the patient or person for whom emergency services and care is requested.

(b) Any hospital employee, physician, other licensed emergency room health care personnel, or certified prehospital emergency personnel who knows of an apparent violation of this section or the rules adopted *under this section* ~~hereunder~~ shall report the apparent violation to the department ~~on a form prescribed by the department~~ within *30 days* ~~1 week~~ following its occurrence.

(c) *A* ~~No~~ hospital, government agency, or person *may not* ~~shall~~ retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to:~~,~~

1. A physician or other *person* ~~personnel~~ for reporting in good faith an apparent violation of this section or the rules adopted *under this section* ~~hereunder~~ to the department, hospital, medical staff, or any other interested party or government agency;~~.~~

2.~~(d) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to,~~ A physician who *refuses* ~~refused~~ to transfer a patient *if* ~~when~~ the physician determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the *patient; or* ~~person.~~

3. A physician who effectuates the transfer of a patient if the physician determines, within a reasonable medical probability, that failing to transfer the patient will create a medical hazard to the patient.

(5)~~(6)~~ PENALTIES.—

(a) The department may deny, revoke, or suspend a license or impose an administrative fine, not to exceed $10,000 per violation, for the violation of any provision of this section or rules adopted *under this section* ~~hereunder~~.

(b) Any person who suffers personal harm as a result of a violation of this section or the rules adopted hereunder may recover, in a civil action against the responsible *hospital* administrative or medical *staff or* personnel, damages, reasonable attorney's fees, and other appropriate relief. *However, this paragraph does not create a cause of action beyond that recognized by this section and rules adopted under this section as they existed on April 1, 1992.*

(c) Any *hospital* administrative or medical *staff or* personnel who knowingly or intentionally violates any provision of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(d)1. Any hospital, or any physician licensed under chapter 458 or chapter 459, which suffers a financial loss as a direct result of a violation by a physician or a hospital of a requirement of this section may, in a civil action against the physician or the hospital, obtain damages for financial loss of charges and such equitable relief as is appropriate, including reasonable attorney's fees and costs.

2. If the defendant prevails in an action brought by the hospital or physician pursuant to this paragraph, the court may award reasonable attorney's fees and costs to the defendant.

(e) A physician licensed under chapter 458 or chapter 459 who negligently or knowingly violates any requirement of this section related to the provision of emergency services and care is deemed in violation of the provisions of that chapter for any of the following violations:

1. Failure or refusal to respond within a reasonable time after notification when on call.

2. Failure or refusal to sign a certificate of transfer as required by this section.

3. Signing a certificate of transfer which states that the medical benefits to be reasonably expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knows or should know that the benefits do not outweigh the risks.

4. Misrepresentation of an individual's condition or other information when requesting a transfer.

Any fine collected for a violation of this section, including a fine collected from a physician licensed under chapter 458 or chapter 459, shall be deposited into the Public Medical Assistance Trust Fund.

(f) The department shall report to the Department of Professional Regulation any violation of this section by a professional who is licensed or certified by the Department of Professional Regulation, if the department has reason to believe that there may have been a violation of this part or any statute or rule relating to a profession under the jurisdiction of the Department of Professional Regulation.

(g) In determining whether a licensee is deemed in violation of this section and in assessing any penalties for violation of this section, the department shall consider, and the licensee may offer as an affirmative defense or in mitigation, whether the licensee has established that the alleged violation arose from an unanticipated change in service capability or other factor beyond the licensee's control.

(6)~~(7)~~ RIGHTS OF PERSONS BEING TREATED.—A person who is being involuntarily examined under the provisions of s. 394.463(2)(a) and is being evaluated or treated at a hospital for an emergency medical condition shall be afforded the rights of patients specified in s. 394.459. These rights shall be afforded to the person regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under chapter 394, and regardless of whether the person is admitted. The patient must be examined under s. 394.463(2)(c) within 72 hours. The 72-hour detainment period specified in s. 394.463 begins when the patient arrives at the hospital *and*~~,~~ ceases when the attending physician documents that the patient has an emergency medical condition~~, and resumes after a physician documents that the patient is stabilized and that the emergency condition is alleviated. If the hospital is not a receiving facility designated under chapter 394,~~ One of the following must occur within 12 hours after the physician documents that the patient's emergency medical condition has stabilized ~~and appropriate medical treatment is available at the designated receiving facility to which the patient is being transferred~~ or that an emergency medical condition does not exist:

(a) The patient must be evaluated by a designated receiving facility, *as defined in s. 394.455,* and released; or

(b) The patient must be transferred to a designated receiving facility *where appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.*

Section 20. Section 395.0175, Florida Statutes, is transferred, renumbered as section 395.1046, Florida Statutes, and amended to read:

395.1046 ~~395.0175~~ Complaint investigation procedures.—

(1) The department shall investigate any complaint against a hospital for any violation of s. *395.1041 or s. 395.1042* ~~395.0142, s. 395.0143, or s. 395.0144~~ which *the department reasonably believes to be* ~~is filed before it, if the complaint is in writing, signed by the complainant, and~~ legally sufficient. A complaint is legally sufficient if it contains ultimate facts which show that a violation of this chapter, or any rule adopted under this chapter by the department, has occurred. The department may investigate, or continue to investigate, and may take appropriate final action on a complaint, even though the original complainant withdraws his complaint or otherwise indicates his desire not to cause it to be investigated to completion. When an investigation of any person or facility is undertaken, the department shall notify such person *in writing* of the investigation and inform the person or facility *in writing* of the substance *and the source* of any complaint filed against him. The department may conduct an investigation without notification to any person if the act under investigation is a criminal offense. *The department shall have access to all records necessary for the investigation of the complaint.*

(2) The department or its agent shall expeditiously investigate each complaint against a hospital for a violation of s. *395.1041 or s. 395.1042* ~~395.0142, s. 395.0143, or s. 395.0144~~. When its investigation is complete, the department shall prepare an investigative report. The report shall contain the investigative findings and the recommendations of the department concerning the existence of probable cause.

(3) The complaint and all information obtained pursuant to the investigation by the department are exempt from s. 119.07(1) and may not be disclosed until 10 days after probable cause has been found to exist by the department, or until the person who is the subject of the investigation waives his privilege of confidentiality, whichever occurs first. This exemption from s 119 07(1) is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

Section 21. Section 395.005, Florida Statutes, is transferred, renumbered as section 395.1055, Florida Statutes, and amended to read:

395.1055 ~~395.005~~ Rules and enforcement.—

(1) The department shall adopt, amend, promulgate, and enforce rules to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(a) Sufficient numbers and qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care and safety;

(b) Infection control, housekeeping, sanitary conditions, emergency management plan, and medical record procedures that will adequately protect patient care and safety are established and implemented;

(c) Construction, maintenance, repair, life safety, and renovation of licensed facilities are governed by the most recently adopted, nationally recognized life-safety code, except as may be specifically modified by rule;

(d) The use of seclusion and restraint is consistent with the rights of mentally ill persons or patients as provided in s. 394.459.

(e)~~(d)~~ Licensed facilities are established, organized, and operated consistent with established standards and rules; and

(f)~~(e)~~ *Licensed facility* ~~Hospital~~ beds conform to minimum space, equipment, and furnishings standards as specified by the department.

(g)~~(f)~~ All hospitals submit such data as necessary to conduct certificate-of-need reviews required under ss. 381.701-381.715. Such data shall include, but shall not be limited to, patient origin data, hospital utilization data, type of service reporting, and facility staffing data. The department shall not collect data that identifies or could disclose the identity of individual patients. The department shall utilize existing uniform statewide data sources when available and shall minimize reporting costs to hospitals.

(h) Each hospital has a quality improvement program designed according to standards established by its current accrediting organization. This program must enhance quality of care and emphasize quality patient outcomes, corrective action for problems, governing board review, and reporting to the department of standardized data elements necessary to analyze quality of care outcomes. The department shall use existing data, if available, and may not duplicate the efforts of other state agencies in order to obtain data.

(2) Separate standards may be provided for general and specialty hospitals and ambulatory surgical centers.

(3) The department shall *adopt* ~~promulgate~~ rules with respect to the care and treatment of clients in intensive residential treatment programs for children and adolescents and with respect to the safe and healthful development, operation, and maintenance of such programs.

(4) No rule shall be *adopted under this part* ~~promulgated hereunder~~ by the department which would have the effect of denying a license to a *facility* ~~hospital, ambulatory surgical center, or other institution~~ required to be licensed *under this part* ~~hereunder~~, solely by reason of the school or system of practice employed or permitted to be employed by physicians therein, provided that such school or system of practice is recognized by the laws of this state. However, nothing in this subsection shall be construed to limit the powers of the department to provide and require minimum standards for the maintenance and operation of, and for the treatment of patients in, those *licensed facilities* ~~hospitals or ambulatory surgical centers~~ which receive federal aid, in order to meet minimum standards related to such matters in such *licensed facilities* ~~hospitals or ambulatory surgical centers~~ which may now or hereafter be required by appropriate federal officers or agencies in pursuance of federal law or *adopted* ~~promulgated~~ in pursuance of federal law.

(5) Any licensed facility which is in operation at the time of *adoption* ~~promulgation~~ of any applicable rules under this part shall be given a reasonable time, under the particular circumstances, but not to exceed 1 year from the date of such *adoption* ~~promulgation~~, within which to comply with such rules.

Section 22. Section 395.018, Florida Statutes, is transferred, renumbered as section 395.1065, Florida Statutes, and amended to read:

395.1065 ~~395.018~~ Criminal and administrative penalties; injunctions; emergency orders; moratorium.—

(1) Any person establishing, conducting, managing, or operating any *facility* ~~hospital or ambulatory surgical center~~ without a license under this part is guilty of a misdemeanor and, upon conviction, shall be fined not more than *$500* ~~$100~~ for the first offense and not more than *$1,000* ~~$500~~ for each subsequent offense, and each day of continuing violation after conviction shall be considered a separate offense.

(2)(a) The department may deny, revoke, or suspend a license or impose an administrative fine, not to exceed *$1,000* ~~$500~~ per violation, per day, for the violation of any provision of this part or rules *adopted* ~~promulgated~~ hereunder. Each day of violation constitutes a separate violation and is subject to a separate fine.

(b) In determining the amount of fine to be levied for a violation, as provided in paragraph (a), the following factors shall be considered:

1. The severity of the violation, including the probability that death or serious harm to the health or safety of any person will result or has resulted, the severity of the actual or potential harm, and the extent to which the provisions of this part were violated.

2. Actions taken by the licensee to correct the violations or to remedy complaints.

3. Any previous violations of the licensee.

(c) All amounts collected pursuant to this section shall be deposited into the Hospital Licensure Trust Fund.

(3) Notwithstanding the existence or pursuit of any other remedy, the department may maintain an action in the name of the state for injunction or other process to enforce the provisions of this part and rules *adopted* ~~promulgated~~ hereunder.

(4) The department may issue an emergency order immediately suspending or revoking a license when it determines that any condition in the licensed facility presents a clear and present danger to public health and safety.

(5) The department may impose an immediate moratorium on elective admissions to any licensed facility, building, or portion thereof, or service, when the department determines that any condition in the facility presents a threat to public health or safety.

Section 23. Section 395.015, Florida Statutes, is transferred, renumbered as section 395.301, Florida Statutes, and amended to read:

395.301 ~~395.015~~ Itemized patient bill; form and content prescribed by the department.—

(1) *A licensed facility not operated by the state shall notify each patient at the time of admission and at the time of discharge of the patient's right to receive an itemized bill upon request.* Within 7 days following discharge or release from a licensed facility not operated by the state, or within 7 days after the earliest date at which the loss or expense from the service may be determined, the licensed facility providing the service shall, *upon request,* submit to the patient, or to his survivor or legal guardian as may be appropriate, an itemized statement detailing in language comprehensible to an ordinary layman the specific nature of charges or expenses incurred by the patient, which in the initial billing shall contain a statement of specific services received and expenses incurred for such items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit-price data on rates charged by the licensed facility, as ~~may be~~ prescribed by the department.

(2) Each such statement ~~shall~~:

(a) *May* not include charges of hospital-based physicians if billed separately.

(b) *May* not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.

(c) *Shall* list drugs by brand or generic name and *may* not refer to drug code numbers when referring to drugs of any sort.

(d) *Shall* specifically identify therapy treatment as to the date, type, and length of treatment when therapy treatment is a part of the statement. Any person receiving a statement pursuant to this section shall be fully and accurately informed as to each charge and service provided by the institution preparing the statement.

(3) On each such itemized statement, there shall appear the words "A FOR-PROFIT (or NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL CENTER) LICENSED BY THE STATE OF FLORIDA" or substantially similar words sufficient to identify clearly and plainly the ownership status of the licensed facility. *Each itemized statement must prominently display the phone number of the medical facility's patient liaison who is responsible for expediting the resolution of any billing dispute between the patient, or his representative, and the billing department.*

(4) *An itemized bill shall be provided once to the patient's physician at the physician's request, at no charge.* ~~On the basis of a random sample, as approved by the department, copies of the itemized bills shall be given to patients' physicians. The random sample shall include not less than 10 itemized bills per year.~~

(5) In any billing for services subsequent to the initial billing for such services, the patient, or his survivor or legal guardian, may elect, at his option, to receive a copy of the detailed statement of specific services received and expenses incurred for each such item of service as provided in subsection (1).

(6) No physician, dentist, podiatrist, or licensed facility may add to the price charged by any third party except for a service or handling charge representing a cost actually incurred as an item of expense; however, the physician, dentist, podiatrist, or licensed facility is entitled to fair compensation for all professional services rendered. The amount of the service or handling charge, if any, shall be set forth clearly in the bill to the patient.

~~(7) The provisions of subsections (1) and (5) do not apply to patients whose care is totally funded by the state or any of its political subdivisions or by Medicaid.~~

Section 24. Section 395.016, Florida Statutes, is transferred and renumbered as section 395.3015, Florida Statutes.

Section 25. Section 395.0165, Florida Statutes, is transferred, renumbered as section 395.302, Florida Statutes, and amended to read:

395.302 ~~395.0165~~ Patient records; penalties for alteration.—

(1) Any person who fraudulently alters, defaces, or falsifies any medical record, or causes or procures any of these offenses to be committed, *is* ~~shall be~~ guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(2) A conviction under subsection (1) *is* ~~shall~~ also *a ground* ~~be grounds~~ for restriction, suspension, or termination of license privileges.

Section 26. Section 395.017, Florida Statutes, is transferred, renumbered as section 395.3025, Florida Statutes, and amended to read:

395.3025 ~~395.017~~ Patient and personnel records; copies; examination.—

(1) Any licensed facility shall, upon *written* request, and only after discharge of the patient, furnish, in a timely manner, without delays for legal review, to any person admitted therein for care and treatment or treated thereat, or to any such person's guardian, curator, or personal representative, or in the absence of one of those persons, to the next of kin of a decedent or the parent of a minor, or to anyone designated by such person in writing, a true and correct copy of all patient records, including X rays, and insurance information concerning such person, which records are in the possession of the licensed facility, ~~except progress notes and consultation report sections of a psychiatric nature concerning the care and treatment performed by the licensed facility,~~ provided the person requesting such records agrees to pay a charge. The charge *for copies of patient records may include sales tax and postage and, except for nonpaper records that are subject to a charge that may not exceed $2 as provided in s. 28.24(9)(c), may not exceed $1 per page, as provided in s. 28.24(8)(a),* ~~except for X rays, may not exceed the fee charged per page for copying records by the clerk of the county court of the county in which the licensed facility is located.~~ *A fee of up to $1, as provided in s. 28.24(25), may be charged for each year of records searched. A patient whose records are copied or searched for the purpose of continuing to receive medical care is not required to pay a charge for copying or for the search.* The licensed facility shall further allow any such person to examine the original records in its possession, or *microforms* ~~microfilms~~ or other suitable reproductions of the records, upon such reasonable terms as shall be imposed to assure that the records will not be damaged, destroyed, or altered.

(2) The provisions of this section do not apply to *records maintained at* any licensed facility the primary function of which is to provide psychiatric care to its patients, *or to records of treatment for any mental or emotional condition at any other licensed facility. A licensed facility that receives a request by a patient or a patient's legal representative for a copy of any such record may provide a report of examination and treatment in lieu of a copy of the record. Upon the signed written request of a patient that a psychiatric record, or other record of treatment for a mental or emotional condition, be provided to a psychiatrist as defined in s. 394.455, the facility shall provide a copy of the patient's record to the psychiatrist and may not require further application therefor. Such records shall otherwise be held confidential, except as specifically provided by statute.*

(3) This section does not apply to records of alcoholics and intoxicated persons, which are governed by the provisions of 396.112, or to records of drug abusers, which are governed by the provisions of s. 397.053.

(4)~~(3)~~ Patient records shall be confidential and shall not be disclosed without the consent of the person to whom they pertain, but appropriate disclosure may be made without such consent to:

(a) *Licensed facility* ~~Hospital~~ personnel *and attending physicians* for use in connection with the treatment of the patient.

(b) *Licensed facility* ~~Hospital~~ personnel only for ~~internal~~ administrative purposes *or risk management and quality assurance functions* ~~associated with the treatment~~.

(c) The department.

(d)~~(c)~~ The Health Care Cost Containment Board.

(e)~~(d)~~ In any civil or criminal action, unless otherwise prohibited by law, upon the issuance of ~~an~~ subpoena from a court of competent jurisdiction and proper notice by the party seeking such records to the patient or his legal representative.

(f)~~(e)~~ The Department of Professional Regulation upon subpoena issued pursuant to s. 455.223, but the records obtained thereby shall be used solely for the purpose of the Department of Professional Regulation and the appropriate professional board in its investigation, prosecution, and appeal of disciplinary proceedings. If the Department of Professional Regulation requests copies of such records, the facility shall charge no more than its actual copying costs, including reasonable staff time. The records shall be sealed and shall not be available to the public pursuant to s. 119.07(1) or any other statute providing access to records, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause.

(g)~~(f)~~ The department or its agent, for the purpose of establishing and maintaining a trauma registry and for the purpose of ensuring that hospitals and trauma centers are in compliance with the standards and rules established pursuant to ss. *395.401, 395.4015, 395.404, and 395.4045* ~~395.031, 395.032, 395.035, and 395.036~~, and for the purpose of monitoring patient outcome at hospitals and trauma centers which provide trauma care services.

(h)~~(g)~~ The State Nursing Home and Long-Term Care Facility Ombudsman Council and the district nursing home and long-term care facility ombudsman councils, with respect to the records of a patient who has been admitted from a nursing home or long-term care facility, when the councils are conducting an investigation involving the patient as

authorized under part I of chapter 400, upon presentation of identification as a council member by the person making the request. Disclosure under this paragraph shall only be made after a competent patient or the patient's representative has been advised that disclosure may be made and the patient has not objected.

~~(4) The department may examine patient records of a licensed facility for the purpose of epidemiological investigations, provided that the unauthorized release of information by agents of the department which would identify an individual patient constitutes a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.~~

(5) Patient records shall contain information required for completion of birth, death, and *fetal death* ~~stillbirth~~ certificates.

(6) If the content of any record of patient treatment is provided under this section, the recipient, if other than the patient or his representative, may use such information only for the purpose provided, and may not further disclose any information to any other person or entity, unless expressly permitted by the written consent of the patient. A general authorization for the release of medical information is not sufficient for this purpose.

(7)~~(6)~~ Patient records at hospitals and ambulatory surgical centers are exempt from disclosure under s. 119.07(1), except as provided by subsections (1), *(2),* (3), and (4). The exemptions to s. 119.07(1) provided by this section are subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(8)~~(7)~~ A licensed facility may prescribe the content and custody of limited access records which the facility may maintain on its employees. Such records shall be limited to information regarding evaluations of employee performance, including records forming the basis for evaluation and subsequent actions, and shall be open to inspection only by the employee and by officials of the facility who are responsible for the supervision of the employee. The custodian of limited access employee records may release information from such records only upon authorization in writing from the employee or upon order of a court of competent jurisdiction. Such limited access employee records are exempt from the provisions of s. 119.07(1) for a period of 5 years from the date such records are designated limited access records. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

Section 27. Additional regulatory studies.—The Legislature recognizes that there are additional areas and issues affecting the operation and regulation of facilities licensed under sections 395.001-395.3025, Florida Statutes. In keeping with this recognition, the Legislature directs the Department of Health and Rehabilitative Services to develop ad hoc workgroups, whose members include representatives from each affected provider, to study and report back to the Legislature by January 1, 1993, recommendations on the following topics:

(1) Alternative uses, if any, for hospital capacity and premises.

(2) Regulatory requirements, if any, for mobile health units, outpatient beds, and specialized services, including, but not limited to, cardiac catheterization, open-heart surgery, burn units, neonatal intensive care units, and organ transplant programs.

(3) Regulatory requirements for antitrust exemptions, if any, and for mergers, consolidations, or cooperative and collaborative agreements among hospitals or other health care providers.

Section 28. Section 395.031, Florida Statutes, is transferred, renumbered as section 395.401, Florida Statutes, and amended to read:

395.401 ~~395.031~~ Trauma services system plans; verification of trauma centers and pediatric trauma referral centers; procedures; renewal.—

(1) *As used in ss. 395.401-395.405* ~~For the purposes of this section, and ss. 395.032, 395.033, 395.0335, 395.034, 395.035, and 395.036~~, the term:

(a) "Board" means the Health Care Cost Containment Board.

(b) "Charity care" means that portion of hospital charges reported to the department for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 150 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income, but whose family income may in no event exceed four times the federal poverty level for a family of four persons.

~~(a) "Department" means the Department of Health and Rehabilitative Services.~~

(c)~~(d)~~ "Level I trauma center" means a hospital that is determined by the department to be in substantial compliance with trauma center and pediatric trauma referral center verification standards as established by rule of the department ~~pursuant to subsection (5)~~, and which:

1. Has formal research and education programs for the enhancement of trauma care.

2. Serves as a resource facility to level II trauma centers, pediatric trauma referral centers, and community hospitals.

3. Ensures an organized system of trauma care.

(d)~~(e)~~ "Level II trauma center" means a hospital that is determined by the department to be in substantial compliance with trauma center verification standards as established by rule of the department ~~pursuant to subsection (5)~~, and which:

1. Serves as a resource facility to community hospitals.

2. Ensures an organized system of trauma care.

(e)~~(b)~~ "Local ~~or regional~~ trauma agency" means an agency established and operated by *a* ~~the~~ county *or*, an entity with which the county contracts for the *purpose of administrative trauma services* ~~purposes of local trauma services administration, or a regional agency created for the administration of trauma services by agreement between counties~~.

(f) "Pediatric trauma referral center" means a hospital that is determined to be in substantial compliance with pediatric trauma referral center standards as established by rule of the department ~~pursuant to subsection (5)~~.

(g) "Regional trauma agency" means an agency created and operated by two or more counties, or an entity with which two or more counties contract, for the purpose of administering trauma services.

(h) "State-approved trauma center" means a hospital that has successfully completed the state-approved selection process pursuant to s. 395.4025 and has been approved by the department to operate as a trauma center in the state.

(i) "State-sponsored trauma center" means a state-approved trauma center that receives state funding for trauma care services.

(j)~~(c)~~ "Trauma center" means any hospital that has been determined by the department to be in substantial compliance with trauma center verification standards.

(k)~~(g)~~ "Trauma scorecard" means a statewide methodology adopted by the department by rule under which a person who has incurred a traumatic injury is graded as to the severity of his injuries or illness and which methodology is used as the basis for making destination decisions.

(l)~~(h)~~ "Trauma victim" means any person who has incurred a single or multisystem life-threatening injury due to blunt or penetrating means and who requires immediate medical intervention or treatment.

~~(i) "State-sponsored trauma centers" means those selected by the department to receive state funding for the purpose of furnishing trauma care services.~~

(2)(a) The local *and* ~~or~~ regional trauma *agencies* ~~agency~~ shall plan, implement, and evaluate ~~a~~ trauma services *systems* ~~system~~, in accordance with this section and ss. *395.4015, 395.404, and 395.4045* ~~395.032, 395.035, and 395.036~~, which *consist* ~~consists~~ of ~~an~~ organized *patterns* ~~pattern~~ of readiness and response services based on public and private agreements and operational procedures.

(b) The local *and* ~~or~~ regional trauma *agencies* ~~agency~~ shall develop and submit to the department *plans for* ~~a plan for a~~ local *and* ~~or~~ regional trauma services *systems* ~~system~~. *Each* ~~The~~ plan must include, at a minimum, the following components:

1. The organizational structure of the trauma system.

2. Prehospital care management guidelines for triage and transportation of trauma cases.

3. Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provision for interfacility transfer.

4. The number and location of needed state-approved trauma centers based on local needs, population, and location and distribution of resources.

~~5.~~ Data collection regarding system operation and patient outcome.

~~6.~~ Periodic performance evaluation of the trauma system and its components.

~~7.~~ The *use* ~~utilization~~ of air transport services within the jurisdiction of the local trauma agency.

~~8.~~ Public information and education about the trauma system.

~~9.~~ Emergency medical services communication system usage and dispatching.

~~10.~~ The coordination and integration between the verified trauma care facility and the nonverified health care facilities.

11.~~10.~~ Medical control and accountability.

12.~~11.~~ Quality control and system evaluation.

(c) The department shall receive plans for the implementation of trauma care systems from local *and* ~~or~~ regional trauma agencies. The department may approve or not approve *a* ~~the~~ local or regional trauma agency *plan* ~~plans~~ based on the conformance of the *plan* ~~local or regional plans~~ with this section and ss. *395.4015, 395 404, and 395 4045* ~~395.032, 395.035, and 395.036~~ and the rules adopted by the department pursuant to those sections. *The department shall approve or disapprove a plan within 120 days after the date the plan is submitted to the department.*

(d) A trauma agency shall not operate unless the department has approved the local or regional trauma services system plan of the agency.

(e) The department may grant an exception to a portion of the rules adopted pursuant to this section or *s. 395.4015* ~~s. 395.032~~ if the local or regional trauma agency proves that, as defined in the rules, compliance with that requirement would not be in the best interest of the persons served within the affected local or regional trauma area.

(f) A local or regional trauma agency may implement a trauma care system only if the system meets the minimum standards set forth in the rules for implementation established by the department and if the plan has been submitted to, and approved by, the department. *At least 60 days* before *a* ~~the~~ local or regional trauma agency submits *a* ~~the~~ plan for *a* ~~the~~ trauma care system to the department, the agency shall hold a public hearing and give adequate notice of the public *hearing* ~~meeting~~ to all hospitals and other interested parties in the area to be included in the proposed system.

(g) Local or regional trauma agencies may enter into contracts for the purpose of implementing the local or regional plan. If local or regional agencies contract with hospitals *for trauma services*, such agencies must contract only with hospitals which are verified trauma centers.

(h) Local or regional trauma agencies providing service for more than one county shall, as part of their formation, establish interlocal agreements between or among the several counties in the regional system.

(i) This section does not restrict the authority of a health care facility to provide service for which it has received a license pursuant to this chapter.

(j) Any hospital which is verified as a trauma center shall accept all trauma victims that are appropriate for the facility regardless of race, sex, creed, or ability to pay.

(k) It is unlawful for any hospital or other facility to hold itself out as a trauma center unless it has been so verified.

(l) A county, upon the recommendations of the local or regional trauma agency, may adopt ordinances governing the transport of a patient who is receiving care in the field from prehospital emergency medical personnel when the patient meets specific criteria for trauma, burn, or pediatric centers adopted by the local or regional trauma agency. These ordinances *must* ~~shall~~ be consistent with *s. 395.4045, ordinances adopted under s 401.25(6), and the local or regional trauma system plan* ~~s. 395.036~~ and, to the furthest possible extent, *must* ensure that individual patients receive appropriate medical care while protecting the interests of the community at large by making maximum use of available emergency medical care resources.

(m) The local or regional trauma agency shall, consistent with the regional trauma system plan, coordinate and otherwise facilitate arrangements necessary to develop a trauma services system.

(n) After the submission of the initial local or regional trauma care system plan, each local or regional trauma agency shall annually submit to the department for approval an updated plan which identifies the changes, if any, to be made in the trauma care system. *The department shall approve or disapprove the updated plan within 120 days after the date the plan is submitted to the department. At least 60 days before the local or regional trauma agency submits a plan for a trauma care system to the department, the agency shall hold a public hearing and give adequate notice of the public hearing to all hospitals and other interested parties in the area.* A local or regional trauma agency shall submit to the department written notice of its intent to cease operation of the local or regional trauma agency at least 90 days before the date on which the local or regional trauma agency will cease operation.

(o) This section does not preclude a local or regional trauma agency from adopting trauma care system standards.

(3) The department shall adopt, by rule, standards for verification of trauma centers based on national guidelines, including those established by the American College of Surgeons entitled "Hospital and Prehospital Resources for Optimal Care of the Injured Patient" and published appendices thereto. Standards specific to pediatric trauma referral centers shall be developed in conjunction with Children's Medical Services and adopted by rule of the department.

(4) The department may withdraw local or regional agency authority, prescribe corrective actions, or use the administrative remedies as provided in *s. 395.1065* ~~s. 395.018~~ for the violation of any provision of this section and ss. *395.4015, 395.402, 395.4025, 395.403, 395.404, and 395.4045* ~~395.032, 395.033, 395.0335, 395.034, 395.035, and 395.036~~ or rules adopted thereunder. All amounts collected pursuant to this subsection shall be deposited into the Emergency Medical Services Trust Fund provided in s. 401.34.

Section 29. Section 395.032, Florida Statutes, is transferred and renumbered as section 395.4015, Florida Statutes.

Section 30. Section 395.033, Florida Statutes, is transferred, renumbered as section 395.402, Florida Statutes, and amended to read:

395.402 ~~395.033~~ Trauma service areas; number and location of trauma centers.—

(1) ~~LEGISLATIVE FINDINGS AND INTENT.~~—The Legislature finds that it is appropriate to recognize as a trauma patient someone with an injury severity score (ISS) of 9 or greater. The Legislature also recognizes that Level I and Level II trauma centers should each be capable of annually treating a minimum of 1,000 and 500 patients, respectively, with an injury severity score of 9 or greater. Further, the Legislature finds that, based on the numbers and locations of trauma victims with these injury severity scores, there should be 19 trauma service areas in the state, and, at a minimum, there should be at least one trauma center in each service area.

(2) It is the intent of the Legislature that, as a planning guideline, Level I and Level II trauma centers should generally each provide care annually to a minimum of 1,000 and 500 patients, respectively. Level II trauma centers in counties of more than 500,000 population are expected to be able to care for 1,000 patients per year, as a planning guideline.

(3) The following trauma service areas are to be utilized in developing a system of state-sponsored trauma centers. These areas are subject to periodic revision by the Legislature based on recommendations made as part of local or regional trauma plans approved by the department pursuant to *s. 395.401(2)* ~~s. 395.031(3)~~. These areas shall, at a minimum, be reviewed by the Legislature prior to the next 7-year verification cycle of state-sponsored trauma centers.

(a) The following trauma service areas are hereby established:

1. Trauma service area 1 shall consist of Escambia, Okaloosa, Santa Rosa, and Walton Counties.

2. Trauma service area 2 shall consist of Bay, Gulf, Holmes, and Washington Counties.

3. Trauma service area 3 shall consist of Calhoun, Franklin, Gadsden, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla Counties.

4. Trauma service area 4 shall consist of Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties.

5. Trauma service area 5 shall consist of Baker, Clay, Duval, Nassau, and St. Johns Counties.

6. Trauma service area 6 shall consist of Citrus, Hernando, and Marion Counties.

7. Trauma service area 7 shall consist of Flagler and Volusia Counties.

8. Trauma service area 8 shall consist of Lake, Orange, Osceola, Seminole, and Sumter Counties.

9. Trauma service area 9 shall consist of Pasco and Pinellas Counties.

10. Trauma service area 10 shall consist of Hillsborough County.

11. Trauma service area 11 shall consist of Hardee, Highlands, and Polk Counties.

12. Trauma service area 12 shall consist of Brevard and Indian River Counties.

13. Trauma service area 13 shall consist of DeSoto, Manatee, and Sarasota Counties.

14. Trauma service area 14 shall consist of Martin, Okeechobee, and St. Lucie Counties.

15. Trauma service area 15 shall consist of Charlotte, Glades, Hendry, and Lee Counties.

16. Trauma service area 16 shall consist of Palm Beach County.

17. Trauma service area 17 shall consist of Collier County.

18. Trauma service area 18 shall consist of Broward County.

19. Trauma service area 19 shall consist of Dade and Monroe Counties.

(b) Each trauma service area should have at least one Level I or Level II trauma center.

(c) There shall be no more than a total of 44 state-sponsored trauma centers in the state.

Section 31. Section 395.0335, Florida Statutes, is transferred, renumbered as section 395.4025, Florida Statutes, and amended to read:

395.4025 ~~395.0335~~ Selection of state-approved trauma centers.—

(1) For purposes of developing a system of state-sponsored trauma centers, the department shall *use* ~~utilize~~ the 19 trauma service areas established in *s. 395.402* ~~s. 395.033~~. Within each service area and based on the state trauma system plan, *the local or regional trauma services system plan, recommendations of the local or regional trauma agency,* and the 1990 Report and Proposal for Funding State-Sponsored Trauma Centers, the department shall establish the approximate number of state-sponsored trauma centers needed to ensure reasonable access to high quality trauma services. Using the guidelines and procedures outlined in the 1990 report, except when in conflict with those prescribed in this section, the department shall select those hospitals which are to be recognized as state-sponsored trauma centers and shall include all trauma centers verified as of October 1, 1990, and subsequently, subject to specific programmatic and quality of care standards.

(2)(a) By September 1, 1990, the department shall notify each acute care general hospital, *each local trauma agency, and each regional trauma agency* in the state that the department is accepting letters of intent from hospitals which are interested in becoming state-sponsored trauma centers. In order to be considered by the department, *any hospital that is not a provisional or verified trauma center on January 1, 1992, and that operates within the geographic area of a local or regional trauma agency must certify that its intent to operate as a state-approved trauma center is consistent with the trauma services plan of the local or regional trauma agency, as approved by the department, if such agency exists* ~~letters of intent must be postmarked no later than midnight October 1, 1990~~.

(b) By October 15, 1990, the department shall send to all hospitals which submitted a letter of intent an application package which will provide the hospitals with instructions for submitting information to the department for selection as a state-sponsored trauma center. The standards for verification of trauma centers and pediatric trauma referral centers provided for in *s. 395.401(3)* ~~s. 395.031(5)~~, as adopted by rule of the department, shall serve as the basis for these instructions.

~~(c) Those hospitals which have been verified trauma centers since December 1, 1989, shall have their current verification period extended to May 1, 1991.~~

(c)~~(d)~~ In order to be considered by the department, applications from those hospitals seeking selection as state-sponsored trauma centers, including those current verified trauma centers which seek to be state-sponsored trauma centers, must be received by the department no later than the close of business on April 1, 1991. The department shall conduct a preliminary review of each application for the purpose of determining that the hospital's application is complete and that the hospital has the critical elements to become a state-sponsored trauma center. This critical review will be based on trauma center verification standards and shall include, but not be limited to, a review of whether the hospital has:

1. Equipment and physical facilities necessary to provide trauma services.

2. Personnel in sufficient numbers and with proper qualifications to provide trauma services.

3. An effective quality assurance process.

4. Submitted written confirmation by the local or regional trauma agency that the verification of the hospital as a state-sponsored trauma center is consistent with the plan of the local or regional trauma agency, as approved by the department, if such agency exists. This provision applies to any hospital that is not a provisional or verified trauma center on January 1, 1992.

(d)~~(e)~~1. Notwithstanding other provisions in this section, the department may grant up to an additional 18 months to a hospital applicant that is unable to meet all requirements as provided in paragraph *(c)* ~~(d)~~ at the time of application if the number of applicants in the service area in which the applicant is located is equal to or less than the service area allocation, as provided by rule of the department. An applicant that is granted additional time pursuant to this paragraph shall submit a plan for departmental approval, which includes timelines and activities, that the applicant proposes to complete in order to meet application requirements. Any applicant that demonstrates an ongoing effort to complete the activities within the timelines outlined in the plan shall be included in the number of state-sponsored trauma centers at such time that the department has conducted a preliminary review of the application and has determined that the application is complete and that the hospital has the critical elements to become a state-sponsored trauma center.

2. Timeframes provided in this section shall be stayed until the department determines that the application is complete and that the hospital has the critical elements to become a state-sponsored trauma center.

(3) After April 30, 1991, and until state-approved trauma centers are selected, any hospital which submitted an application found acceptable by the department based on preliminary review, including all trauma centers verified as of December 1, 1989, shall be eligible to operate as a provisional state-approved trauma center. A hospital with an application found to be unacceptable by the department shall be given opportunity to provide additional information or clarification, but shall not be included within the timeframes outlined in subsections (1)-(8).

(4) Between May 1, 1991, and October 1, 1991, the department shall conduct an in-depth evaluation of all applications found acceptable in the initial review. The applications shall be evaluated against criteria enumerated in the application packages as provided to the hospitals by the department.

(5) Beginning October 1, 1991, and ending no later than June 1, 1992, a review team of out-of-state experts assembled by the department shall make onsite visits to all provisional state-approved trauma centers. The department shall develop a survey instrument to be used by the expert team of reviewers. The instrument shall include objective criteria and guidelines for reviewers based on existing trauma center and pediatric trauma referral center verification standards such that all trauma centers and pediatric trauma referral centers are assessed equally. The survey instrument shall also include a uniform rating system which will be used by reviewers to indicate the degree of compliance of each center with spe-

cific standards, and to indicate the quality of care provided by each center as determined through an audit of patient charts. In addition, hospitals being considered as provisional state-approved trauma centers shall meet all the requirements of a verified trauma center or pediatric trauma referral center, and shall be located in a trauma service area which has a need for such a center.

(6) Based on recommendations from the review team, the department shall select state-approved trauma centers by July 1, 1992. Each state-approved trauma center shall be granted a 7-year verification period during which time it must continue to maintain trauma center verification standards and acceptable patient outcomes as determined by department rule. A verification, unless sooner suspended or revoked, automatically expires 7 years after the date of issuance and is renewable upon application for renewal as prescribed by rule of the department. After July 1, 1992, only those hospitals selected as state-approved trauma centers may operate as trauma centers.

(7) Any hospital which wishes to protest a decision made by the department based on the department's preliminary or in-depth review of applications or on the recommendations of the site visit review team pursuant to this section shall proceed as provided in chapter 120. Hearings held under this subsection shall be conducted in the same manner as provided in s. 120.57. Cases filed under chapter 120 may combine all disputes between parties. ~~Notwithstanding any other applicable provision of statute, when any hospital wishes to protest a decision of the department, the burden of proof shall be on the hospital to demonstrate that such decision is not supported by evidence.~~

(8) Notwithstanding any provision of chapter 381, a hospital *that* ~~licensed under this chapter which~~ operates a state-approved trauma center may not terminate or substantially reduce the availability of trauma service without providing at least 6 months' notice of its intent to terminate such service. Such notice shall be given to the department, *to all affected local or regional trauma agencies,* ~~of Health and Rehabilitative Services~~ and to all state-approved trauma centers, hospitals, and emergency medical *service* ~~services~~ providers in the trauma service area.

(9) The department or its agent may collect trauma *care and* registry data, as prescribed by rule of the department, from trauma centers, pediatric trauma referral centers, hospitals, emergency medical service providers, local or regional trauma agencies, or medical examiners for the purposes of evaluating trauma system effectiveness, ensuring compliance with the standards of verification, and monitoring patient outcomes.

(10) Out-of-state experts assembled by the department to conduct onsite visits, *and local or regional trauma agencies that maintain a trauma registry, monitor compliance with trauma system standards, or monitor patient outcome at hospitals and trauma centers that provide trauma care services,* shall be considered agents of the department for *the purposes of s. 395.3025* ~~this purpose~~. *An out-of-state expert who acts as an agent of the department under this subsection is not liable for any civil damages as a result of actions taken by him, unless he is found to be operating outside the scope of the authority and responsibility assigned by the department.*

(11) Onsite visits by the department or its agent may be conducted at any reasonable time and may include but not be limited to a review of records in the possession of trauma centers, pediatric trauma referral centers, hospitals, emergency medical service providers, local or regional trauma agencies, or medical examiners regarding the care, transport, treatment, or examination of trauma patients.

(12) Patient care, transport, or treatment records or reports, or patient care quality assurance proceedings, records, or reports obtained or made pursuant to this section or *s. 119.07(3)(v), s. 395.3025(4)(g), s. 395.401, s. 395.4015, s. 395.402, s. 395.403, s. 395.404, s. 395.4045, or s. 395.405* ~~s. 119.07(3)(w), s. 395.017(3)(f), s. 395.031, s. 395.032, s. 395.033, s. 395.034, s. 395.035, s. 395.036, or s. 395.037~~ shall be held confidential by the department or its agent and are exempt from the provisions of s. 119.07(1). The exemption from s. 119.07(1) provided by this subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(13) The department is authorized to adopt, by rule, the procedures and process by which it will select state-approved trauma centers in situations other than those provided for in the initial process outlined in subsections (1)-(8). Such procedures and process shall be used in selecting state-approved trauma centers after the dates specified in subsections (1)-(8), *on an annual basis,* and shall be consistent with subsections (1)-(8) in terms of timeframes and guidelines except in those situations in which it is in the best interest of, and mutually agreed to by, all applicants within a service area and the department to reduce the timeframes.

Section 32. Section 395.034, Florida Statutes, is transferred, renumbered as section 395.403, Florida Statutes, and amended to read:

395.403 ~~395.034~~ Reimbursement of state-sponsored trauma centers.—

(1) ~~LEGISLATIVE FINDINGS AND INTENT.—~~*The Legislature* finds that many hospitals which provide services to trauma victims are not adequately compensated for such treatment. The Legislature also recognizes that the current verified trauma centers are providing such services without adequate reimbursement. Therefore, it is the intent of the Legislature to provide financial support to the current verified trauma centers and to establish a system of state-sponsored trauma centers as soon as feasibly possible. It is also the intent of the Legislature that this system of state-sponsored trauma centers be assisted financially based on the volume and acuity of uncompensated trauma care provided.

~~(2) DEFINITIONS.—As used in this section:~~

~~(a) "Board" means the Health Care Cost Containment Board.~~

~~(b) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the department for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 150 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds 4 times the federal poverty level for a family of four be considered charity.~~

~~(c) "Department" means the Department of Health and Rehabilitative Services.~~

~~(d) "Hospital" means a health care institution as defined in s. 395.002(6).~~

~~(e) "State-approved trauma center" means a hospital that has successfully completed the state-approved selection process pursuant to s. 395.0335 and has been approved by the department to operate as a trauma center in the state.~~

~~(f) "State-sponsored trauma center" means a state-approved trauma center which receives state funding for trauma care services.~~

(2)~~(3)~~ All provisional and state-approved trauma centers shall be considered state-sponsored trauma centers when state funds are specifically appropriated for state-sponsored trauma centers in the General Appropriations Act.

(3)~~(4)~~ To receive state funding, a state-sponsored trauma center shall submit a claim electronically via the Trauma Claims Processing System, designed, developed, implemented, and operated by the department's Medicaid program, to the department's Medicaid program upon discharge of a trauma patient. When a hospital stay spans a state fiscal year, a separate hospital claim shall be submitted for the hospital days incurred in each fiscal year.

(4)~~(5)~~(a) State-sponsored trauma centers shall determine each trauma patient's eligibility for state funding prior to the submission of a claim.

(b) A trauma patient treated must meet the definition of charity care, have been designated as having an ISS score of 9 or greater, and have received services that are medically necessary from a state-sponsored trauma center in order for the state-sponsored trauma center to receive state funding for that patient.

(c) Each state-sponsored trauma center shall retain appropriate documentation showing a trauma patient's eligibility for state funding. Documentation recognized by the department as appropriate shall be limited to one of the following:

1. W-2 withholding forms.

2. Payroll stubs.

3. Income tax returns.

4. Forms approving or denying unemployment compensation or workers' compensation.

5. Written verification of wages from employer.

6. Written verification from public welfare agencies or any other governmental agency which can attest to the patient's income status for the past 12 months.

7. A witnessed statement signed by the patient or responsible party, as provided for in Pub. L. No. 79-725, as amended, known as the Hill-Burton Act, except that such statement need not be obtained within 48 hours of the patient's admission to the hospital as required by the Hill-Burton Act. The statement shall include acknowledgment that, in accordance with s. 817.50, providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor of the second degree.

(d) The department shall conduct an audit or shall contract with an independent party to conduct an audit of each state-sponsored trauma center's claims to ensure that state funding was only provided for eligible trauma patients and medically necessary services.

(e) The department's Medicaid program office shall check each claim to confirm that the patient is not covered under the Medicaid program and shall pay the claim out of the Trauma Services Trust Fund. Trauma patients who are eligible for the Medicaid program shall not be considered eligible for the state-sponsored trauma center program except for Medicaid noncovered services. If a claim is denied by the Trauma Claims Processing System as a result of Medicaid eligibility for Medicaid covered services, the hospital shall submit a claim to the Medicaid fiscal agent for payment.

(5) ~~(6) Effective October 1, 1990,~~ State funding shall be at a per diem rate equal to $860 to provisional state-approved and state-approved trauma centers. This rate shall *be effective for the first 12 months of funding, after* ~~remain in effect until July 1, 1991, at~~ which time payment to provisional state-approved and state-approved trauma centers shall be based on a trauma cost-based reimbursement methodology developed by the department ~~of Health and Rehabilitative Services~~. The department shall consult with representatives from the hospital industry including the Florida Hospital Association, the Association of Voluntary Hospitals of Florida, and the Florida League of Hospitals in the development of the reimbursement methodology.

(6) ~~(7)~~(a) To ensure a fair distribution of funds appropriated for state-sponsored trauma centers and to ensure that no state-sponsored trauma center gains an unfair advantage due solely to its ability to bill more quickly than another state-sponsored trauma center, the total amount of state funds appropriated in the General Appropriations Act for this section shall be divided into 19 trauma fund accounts with an account for each service area established in *s. 395.402(3)* ~~s. 395.033(3)~~. The amount of funds distributed to a service area shall be based on the following formula:

$$SAAA = \frac{SATD}{TTD} \times TA$$

where:

SAAA = service area appropriation amount.

SATD = uncompensated service area trauma days with ISS score of 9 or greater.

TTD = uncompensated total trauma days with ISS score of 9 or greater for all 19 service areas.

TA = total dollars appropriated for state-sponsored trauma centers.

(b) The data base to be used for this calculation shall be the detailed patient discharge data of the most recently completed calendar year for which the ~~Health Care Cost Containment~~ board possesses data. Out-of-state days that are included in the data base shall be allocated to the service area where the treating hospital is located.

(c) Fifty percent of the funds allocated to those service areas which had one or more trauma centers as of December 1, 1989, shall be distributed to those verified trauma centers proportionately based on volume and acuity of uncompensated trauma care provided during the most recently completed calendar year for which the ~~Health Care Cost Containment~~ board possesses data in a lump sum payment on *the date that funding becomes available* ~~October 1, 1990~~. These trauma centers shall submit claims pursuant to subsection *(3)* ~~(4)~~ in order to justify this funding. *Effective 9 months after funding becomes available* ~~By June 30, 1991~~, any trauma center which fails to submit claims for reimbursement equal to or greater than the amount the trauma center received under the initial allocation shall return any unearned funds to the department for distribution pursuant to paragraph (e). Once this 50-percent lump sum is depleted, a trauma center will be reimbursed from the remaining 50 percent of the service area's original allocation.

(d) The department shall pay trauma claims on a monthly basis. In a given month when the outstanding claims will exceed the unexpended funds allocated to a service area, the department shall pay all of the submitted claims for the service area on a pro rata basis.

(e) At the end of the fiscal year, the unexpended funds for each service area shall be placed in one large state trauma account from which all remaining claims are paid without regard to service area on a pro rata basis until such funds are depleted.

(f) For any state fiscal year, reimbursement for any patient residing outside the trauma service area of the state-sponsored trauma center where the patient is treated shall be paid out of the funds allocated for the trauma service area where the patient resides. Out-of-state days shall be paid from the service area where the treating hospital is located.

(7) ~~(8)~~ In order to receive payments under this section, a hospital shall be a state-sponsored trauma center and shall:

(a) Agree to conform to all departmental requirements as provided by rule to assure high quality trauma services.

(b) Agree to provide information concerning the provision of trauma services to the department, in a form and manner prescribed by rule of the department.

(c) Agree to accept all trauma patients, regardless of ability to pay, on a functional space-available basis.

(8) ~~(9)~~ A state-sponsored trauma center which fails to comply with any of the conditions listed in subsection *(7)* ~~(8)~~ or the applicable rules of the department shall not receive payments under this section for the period in which it was not in compliance.

(9) ~~(10)~~ Funds distributed to a hospital pursuant to this section shall not be considered as net revenues of such hospital in determining whether an excess has occurred pursuant to s. 407.51.

Section 33. Section 395.0345, Florida Statutes, is transferred and renumbered as section 395.4035, Florida Statutes.

Section 34. Section 395.035, Florida Statutes, is transferred, renumbered as section 395.404, Florida Statutes, and amended to read:

395.404 ~~395.035~~ Review of trauma registry data; proceedings, records, and reports specified confidential.—

(1) ~~Effective October 1, 1988,~~ Each trauma center shall furnish, and all acute care hospitals shall *furnish for department review* ~~maintain and allow for department review of~~, trauma registry data as prescribed by rule of the department for the purpose of monitoring patient outcome and ensuring compliance with the standards of *approval* ~~verification~~. ~~Acute care hospitals having 300 beds or more shall furnish the department trauma registry data effective October 1, 1989. Acute care hospitals having fewer than 300 beds shall furnish the department trauma registry data effective October 1, 1990. Notwithstanding this schedule, any acute care hospital may submit trauma registry data prior to the dates established in this schedule.~~

(2) Notwithstanding the provisions of ss. 413.48 and 413.612, each trauma center and acute care hospital shall submit severe disability and head-injury registry data to the department as provided by rule in lieu of submitting such registry information to the Department of Labor and Employment Security. Each trauma center and acute care hospital shall continue to provide initial notification of severe disabilities and head injuries to the Department of Labor and Employment Security within timeframes provided in chapter 413. Such initial notification shall be made in the manner prescribed by the Department of Labor and Employment Security for the purpose of providing timely vocational rehabilitation services to the severely disabled or head-injured person. ~~The schedule provided in subsection (1) does not apply to the current requirement for reporting of severe disabilities and head injuries but applies only to the requirement for providing trauma registry information.~~

(3) Patient care quality assurance proceedings, records, or reports made pursuant to this section or s. 119.07(3)(v), *s. 395.3025(4)(g), s. 395.401, or s. 395.4015* ~~s. 395.017(3)(f), s. 395.031, or s. 395.032~~ shall be held confidential within the hospital and *by* the department and *its agents and by any entity subject to the quality assurance review process which receives oral or written quality assurance records or reports. Such proceedings, records, and reports are not* ~~shall not be~~ available to the public pursuant to s. 119.07(1) or any other law providing access to public records or ~~be~~ discoverable or admissible in any civil or administrative action. A person in attendance at such proceedings may not be required to testify as to what transpired at the meeting. The exemption from the public records law provided by this subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

Section 35. Section 395.036, Florida Statutes, is transferred, renumbered as section 395.4045, Florida Statutes, and amended to read:

395.4045 ~~395.036~~ Emergency medical service providers; transport of trauma victims to trauma centers.—

(1) Each emergency medical services provider licensed under chapter 401 shall transport trauma victims to hospitals *approved* ~~verified~~ as trauma centers, except as may be provided for either in department approved local or regional trauma transport protocol or, if no local or regional trauma transport protocol is in effect, as provided for in a department-approved provider's trauma transport protocol. Development of regional trauma protocols shall be through consultation with interested parties, including, but not limited to, each *approved* ~~verified~~ trauma center in the region; physicians specializing in trauma care, emergency care, and surgery *in the region*; *each* trauma system *administrator in the region* ~~administrators~~; and *each* emergency medical service *provider in the region which is* ~~providers~~ licensed under chapter 401. Trauma victims shall be identified through the use of a trauma scoring system. The department shall specify by rule the subjects to be included in an emergency medical service provider's trauma transport protocol and shall approve or disapprove each such protocol.

(2) If an air ambulance service is available in the trauma service area in which an emergency medical service provider is located, trauma transport protocols may not provide for transport outside the trauma service area unless otherwise provided for by written mutual agreement. If air ambulance service is not available and there is no agreement for interagency transport of trauma patients between two adjacent local or regional trauma agencies, both of which include at least one approved trauma center, a trauma patient with an immediately life-threatening condition must be transported to the most appropriate trauma center as defined pursuant to trauma transport protocols approved by the department. This subsection applies only in those counties having populations in excess of 1 million residents.

Section 36. Section 395.037, Florida Statutes, is transferred, renumbered as section 395.405, Florida Statutes, and amended to read:

395.405 ~~395.037~~ Rulemaking authority.—The department ~~of Health and Rehabilitative Services~~ shall adopt rules to implement *ss 395.401-395.4045* ~~ss. 395.0172, 395.031, 395.032, 395.033, 395.0335, 395.034, 395.035, and 395.036~~.

Section 37. Section 395.102, Florida Statutes, is transferred, renumbered as section 395.602, Florida Statutes, and amended to read:

395.602 ~~395.102~~ Rural hospitals.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that rural hospitals are the nucleus or "backbone" of rural health care systems. Public health programs and physicians depend on rural hospitals to meet many of their medical needs. Rural hospitals are usually the only source of emergency medical care in rural areas for life-threatening situations and play a crucial role in attracting physicians to rural areas. The Legislature deems the benefits derived from these features to be truly significant as rural counties with hospitals have lower accidental death rates and lower incidence of low birth weight than rural counties without hospitals. In addition, rural hospitals enhance their communities beyond the scope of health care as they are among the largest employers in rural areas and substantially foster economic development and growth. For these reasons, the Legislature finds that rural hospitals are widely viewed as integral to the welfare of rural communities. However, the rural health care system is experiencing significant instability as the financial viability of many of these hospitals is threatened. The Legislature finds that sharply declining occupancy rates, increasing dependence on Medicaid and Medicare reimbursements, liability concerns, frequent changes in ownership, high levels of bad debt, greater competition on more sophisticated levels with urban hospitals, and physician and personnel staffing problems threaten the existence of some rural hospitals.

(b) It is the intent of the Legislature to ease the burdens experienced by rural hospitals in personnel staffing by:

1. Providing financial incentives under the Medical Education Tuition Reimbursement Program in order to increase the number of primary care physicians and nurses in rural areas; and

2. Requiring a study of problems unique to rural hospitals generated by existing licensure and certification requirements for allied health care practitioners in the state.

(c) In addition, it is the intent of the Legislature to ease the severe financial constraints being experienced by some rural hospitals by extending Medicaid reimbursements to rural hospital swing-beds and establishing the full utilization, when feasible, of rural hospital services by departmental primary care programs and programs serving the elderly citizens of the state.

(d) Furthermore, the Legislature encourages the department ~~of Health and Rehabilitative Services~~ to actively foster the provision of health care services in rural areas and serve as a catalyst for improved health services to citizens in rural areas of the state. Among other considerations, the department is encouraged to:

1. Promote the location and relocation of health care practitioners in rural areas.

2. Further analyze the financial viability of rural hospitals and their continued existence in rural counties.

3. Integrate policies related to physician manpower, hospitals, primary care, and state regulatory functions.

4. Collect relevant data on rural health care issues for use in departmental policy development.

5. Propose solutions for problems affecting health care delivery in rural areas.

(2) DEFINITIONS.—As used in *ss. 395.602-395.605, the term* ~~this act~~:

(a) "Emergency care hospital" means a medical facility that provides:

1. Emergency medical treatment; and

2. Inpatient care to ill or injured persons prior to their transportation to other hospitals or provides inpatient medical care to persons needing care for periods of up to 96 hours. The 96-hour limitation on inpatient care does not apply to respite, skilled nursing, hospice, or other nonacute care patients.

(b) "Essential access community hospital" means any facility that:

1. Has at least 100 beds;

2. Is located more than 35 miles from any other essential access community hospital, rural referral center, or urban hospital meeting criteria for classification as a regional referral center;

3. Is part of a network that includes rural primary care hospitals;

4. Provides emergency and medical backup services to rural primary care hospitals in its rural health network;

5. Extends staff privileges to rural primary care hospital physicians in its network; and

6. Accepts patients transferred from rural primary care hospitals in its network.

(c) "Inactive rural hospital bed" means a licensed acute care hospital bed that is inactive in that it cannot be occupied by acute care inpatients.

(d)~~(b)~~ "Rural area health education center" means an area health education center (AHEC), as authorized by Pub. L. No. 94-484, which provides services in a county with a population density of no greater than 100 persons per square mile.

(e)~~(a)~~ "Rural hospital" means an acute care hospital licensed under *this* chapter ~~395~~, with 85 licensed beds or less, which has an emergency room and is located in an area defined as rural by the United States Census, and which is:

1. The sole provider within a county with a population density of no greater than 100 persons per square mile; ~~or~~

2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county; or

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.

(f) "Rural primary care hospital" means any facility that meets the criteria specified in paragraph (e) or s. 395.605 which provides:

1. Twenty-four-hour emergency medical care;

2. Temporary inpatient care for periods of 72 hours or less to patients requiring stabilization before discharge or transfer to other hospitals. The 72-hour limitation does not apply to respite, skilled nursing, hospice, or other nonacute care patients; and

3. Has no more than six licensed acute care inpatient beds.

(g)~~(c)~~ "Swing-bed" means a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to *42 C.F.R.* ~~the Code of Federal Regulations~~, parts 405, 435, 440, 442, and 447.

(3) USE OF FUNDS.—It is the intent of the Legislature that funds as appropriated shall be utilized by the department ~~of Health and Rehabilitative Services~~ for the purpose of increasing the number of primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses in rural areas, either through the Medical Education Reimbursement and Loan Repayment Program as defined by s. 240.4067 or through a federal loan repayment program which requires state matching funds. The department may use funds appropriated for the Medical Education Reimbursement and Loan Repayment Program as matching funds for federal loan repayment programs for health care personnel, such as that authorized in s. 203 of Pub. L. No. 100-177. If the department receives federal matching funds, the department shall only implement the federal program. Reimbursement through either program shall be limited to:

(a) Primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural hospitals~~, as defined in this act~~; and

(b) Primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural area health education centers~~, as defined in this act~~. These personnel shall practice:

1. In a county with a population density of no greater than 100 persons per square mile; or

2. Within the boundaries of a hospital tax district which encompasses a population of no greater than 100 persons per square mile.

If the department administers a federal loan repayment program, priority shall be given to obligating state and federal matching funds pursuant to paragraphs (a) and (b). The department may use federal matching funds in other health manpower shortage areas and medically underserved areas in the state for loan repayment programs for primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses who are employed by publicly financed health care programs that serve medically indigent persons.

(4) RULEMAKING AUTHORITY.—The department *may* ~~of Health and Rehabilitative Services is hereby authorized to~~ adopt all necessary rules pertaining to the standards of care applicable to rural hospital swing-beds and the criteria whereby swing-bed stays of longer than 30 days shall be authorized. The latter length-of-stay criteria shall include, but not be limited to, the medical needs of the patient, the county of residence of the patient and patient's family, patient preference, proximity to relatives and friends, and distance to available nursing home beds, if any.

Section 38. Effective upon this act becoming a law, section 395.103, Florida Statutes, is transferred, renumbered as section 395.603, Florida Statutes, and amended to read:

395.603 ~~395.103~~ Rules; rural hospital impact statement.—

(1) The department shall establish, by rule, a process by which a rural hospital that seeks licensure as a rural primary care hospital or as an emergency care hospital, or that becomes a certified rural health clinic, as defined in Pub. L. No. 95-210, or becomes a primary care program such as a county public health unit, community health center, or other similar outpatient program that provides preventive and curative services, may deactivate general hospital beds. Rural primary care hospitals and emergency care hospitals shall maintain the number of actively licensed general hospital beds necessary for the facility to be certified for Medicare reimbursement. Hospitals that discontinue inpatient care to become rural health care clinics or primary care programs must deactivate all licensed general hospital beds. All hospitals, clinics, and programs with inactive beds shall provide 24-hour emergency medical care by staffing an emergency room. Providers with inactive beds are subject to the criteria specified in s. 395.1041. The department shall specify, in rule, requirements for making 24-hour emergency care available. Inactive general hospital beds must be included in the acute care bed inventory maintained by the department for certificate-of-need purposes, for 10 years after the date of deactivation of the beds. After 10 years have elapsed, inactive beds must be excluded from the inventory. The department shall, at the request of the licensee, reactivate the inactive general beds upon a showing by the licensee that licensure requirements for the inactive general beds are met.

(2) In formulating and implementing policies and rules that may have significant impact on the ability of rural hospitals to continue to provide health care services in rural communities, the Department of Health and Rehabilitative Services, the Department of Professional Regulation, or the respective regulatory board promulgating policies or rules regarding the licensure or certification of health care practitioners shall provide a rural hospital impact statement. The rural hospital impact statement shall assess the proposed action in light of the following questions:

(a)~~(1)~~ Do the health personnel affected by the proposed action currently practice in rural hospitals or are they likely to in the near future?

(b)~~(2)~~ What are the current numbers of the affected health personnel in this state, their geographic distribution, and the number practicing in rural hospitals?

(c)~~(3)~~ What are the functions presently performed by the affected health personnel, and are such functions presently performed in rural hospitals?

(d)~~(4)~~ What impact will the proposed action have on the ability of rural hospitals to recruit the affected personnel to practice in their facilities?

(e)~~(5)~~ What impact will the proposed action have on the limited financial resources of rural hospitals through increased salaries and benefits necessary to recruit or retain such health personnel?

(f)~~(6)~~ Is there a less stringent requirement which could apply to practice in rural hospitals?

(g)~~(7)~~ Will this action create staffing shortages, which could result in a loss to the public of health care services in rural hospitals or result in closure of any rural hospitals?

Section 39. Section 395.104, Florida Statutes, is transferred, renumbered as section 395.604, Florida Statutes, and amended to read:

395.604 ~~395.104~~ Other rural hospital programs.—

(1) The department may license rural primary care hospitals subject to federal approval for participation in the Medicare and Medicaid programs. Rural primary care hospitals shall be treated in the same manner as emergency care hospitals and rural hospitals with respect to ss. 381.703(3)(b)3., 381.708, and *395.605(2)-(8)(a)* ~~395.01465(2)-(8)(a)~~.

(2) The department may designate essential access community hospitals.

(3) The department may adopt licensure rules for rural primary care hospitals and essential access community hospitals. Such rules must conform to *s. 395.1055* ~~s. 395.005~~.

(4) The department may seek federal recognition of emergency care hospitals authorized by *s. 395.605* ~~s. 395.01465~~ under the essential access community hospital program authorized by the Omnibus Budget Reconciliation Act of 1989.

Section 40. Section 395.01465, Florida Statutes, is transferred, renumbered as section 395.605, Florida Statutes, and amended to read:

395.605 ~~395.01465~~ Emergency care hospitals.—

(1) Only *rural* hospitals ~~meeting the criteria in s. 395.102(2)~~ may be licensed as emergency care hospitals ~~as defined in s. 395.002~~.

(2) For the purpose of Medicaid swing-bed reimbursement pursuant to the Medicaid program, the department shall treat emergency care hospitals in the same manner as *rural* hospitals ~~defined in s. 395.102(2)~~.

(3) For the purpose of participation in the Medical Education Reimbursement and Loan Repayment Program as defined in s. 240.4067 or other loan repayment or incentive programs designed to relieve medical manpower shortages, the department shall treat emergency care hospitals in the same manner as *rural* hospitals ~~defined in s. 395.102(2)~~.

(4) For the purpose of coordinating primary care services described in s. 154.011(1)(c)10. and aging services described in s. 410.016(2)(n), the department shall treat emergency care hospitals in the same manner as *rural* hospitals ~~defined in s. 395.102(2)~~.

(5) *Rural* hospitals *that* ~~defined in s. 395.102(2) which~~ make application under the certificate-of-need program to be licensed as emergency care hospitals shall receive expedited review as defined in s. 381.702(6). Emergency care hospitals seeking relicensure as acute care general hospitals shall also receive expedited review.

(6) The Health Care Cost Containment Board shall treat emergency care hospitals in the same manner as hospitals defined in s. 407.002(24).

(7) Emergency care hospitals are exempt from certificate-of-need requirements for home health and hospice services and for swing beds in a number that does not exceed one-half of the facility's licensed beds.

(8) The department shall *adopt* ~~promulgate~~ rules for facility licensure that conform to *s. 395.1055* ~~s. 395.005~~. Rules shall include the following provisions:

(a) Emergency care hospitals shall have agreements with other hospitals, skilled nursing facilities, *and* home health agencies~~,~~ and with providers of diagnostic imaging and laboratory services that are not provided on site but are needed by patients.

(b) All patients shall be under the care of a physician or under the care of a nurse practitioner or physician assistant supervised by a physician.

(c) A physician, nurse practitioner, or physician assistant shall be on duty at all times, or a physician shall be on call and available within 30 minutes at all times.

(d) All compounding, packaging, and dispensing of drugs and biologicals shall be under the supervision of a pharmacist.

(e) Diagnostic radiologic services and clinical laboratory services shall be maintained at the facility or shall be available to meet the needs of its patients.

(f) Clinical laboratory services provided by the facility shall, at a minimum, include:

1. Chemical examinations of urine by stick or tablet methods, or both (including urine ketones).

2. Microscopic examinations of urine sediment.

3. Hemoglobin or hematocrit.

4. Blood sugar.

5. Gram stain.

6. Examination of stool specimens for occult blood.

7. Pregnancy tests.

8. Primary culturing for transmittal to a certified laboratory.

9. Sediment rate, CBC.

(9) The department may use specific diagnosis-related groups, ICD-9 codes, or similar patient illness-severity classification schemes to define the scope of inpatient care in emergency care hospitals in lieu of the 96-hour inpatient care limitation. The methodology used for determining the scope of inpatient care permitted in emergency care hospitals shall be included in rule.

Section 41. Section 395.101, Florida Statutes, is transferred, renumbered as section 395.701, Florida Statutes, and amended to read:

395.701 ~~395.101~~ Annual assessments on net operating revenues to fund public medical assistance; administrative fines for failure to pay assessments when due.—

(1) For the purposes of this section, the term:

~~(a) "Department" means the Department of Health and Rehabilitative Services.~~

(a)~~(b)~~ "Gross operating revenue" or "gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges, and other operating revenue.

(b)~~(d)~~ "Health Care Cost Containment Board" or "board" means the Health Care Cost Containment Board created by s. 407.01.

(c) "Hospital" *has the same meaning as that term is* ~~means a health care institution as~~ defined in s. 395.002*(12)*~~(6)~~, but does not include any hospital operated by the Department of Health and Rehabilitative Services or the Department of Corrections.

(d)~~(e)~~ "Net operating revenue" or "net revenue" means gross revenue less deductions from revenue.

(e)~~(f)~~ "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care.

(2) There is hereby imposed upon each hospital an assessment in an amount equal to ~~1 percent of the annual net operating revenue of the hospital for its first fiscal year ending subsequent to May 18, 1984, and in an amount equal to~~ 1.5 percent of *the annual net operating* ~~such~~ revenue for each hospital ~~fiscal year thereafter~~, such revenue to be determined by the board, based on the actual experience of the hospital as reported to the board. Within 6 months after the end of each hospital fiscal year, the board shall certify to the department the amount of the assessment for each hospital. The assessment shall be payable to and collected by the department in equal quarterly amounts, on or before the first day of each calendar quarter, beginning with the first full calendar quarter that occurs after the board certifies to the department the amount of the assessment for each hospital. All moneys collected pursuant to this subsection shall be deposited into the Public Medical Assistance Trust Fund.

(3) The department shall impose an administrative fine, not to exceed $500 per day, for failure of any hospital to pay its assessment by the first day of the calendar quarter on which it is due. The failure of a hospital to pay its assessment within 30 days after the assessment is due is ground for the department to impose an administrative fine not to exceed $5,000 per day.

(4) If an owner or licensee transfers its interest in or terminates its relationship with a hospital, within 15 days after such termination or transfer he shall make payment in full of all assessments, fines, or penalties that are due or have accrued for the period before the transfer or termination. An unpaid assessment, fine, or penalty shall be assumed by the purchaser, successor, or assignee if the purchaser, successor, or assignee withholds the assessment, fine, or penalty from purchase moneys or payments due. A purchaser, successor, or assignee who fails to withhold sufficient funds to pay assessments, fines, or penalties imposed under this section or chapter 407, shall assume full liability for the assessments, fines, and penalties owed and outstanding by the prior owner or licensee. Assessments following the transfer of any hospital shall be based upon the most recently available report or audited actual experience for the hospital for the prior year. The new owner or licensee shall require the prior owner or licensee to produce the audited financial data for the period of operation before the transfer. If the new owner or licensee fails to obtain current audited financial data from the

prior owner or licensee, the new owner or licensee shall be assessed based upon the most recent year of operation for which 12 months of audited actual experience are available or upon a reasonable estimate of 12 months of full operation as calculated by the board.

(5) A statutory teaching hospital that had 100,000 or more Medicaid-covered days during the most recent fiscal year may elect to have the amount of its assessment imposed pursuant to subsection (2) deducted from any Medicaid disproportionate share payment due that hospital for the quarter ending 6 months after the assessment due date. If the assessment is greater than the disproportionate share payment, or if no disproportionate share payment is due the hospital, the difference, or full amount of the assessment in a case in which no payment is due, shall be paid on or before the date the disproportionate share payment is made or would have been made.

Section 42. Section 395.1015, Florida Statutes, is transferred, renumbered as section 395.7015, Florida Statutes, and amended to read:

395.7015 ~~395.1015~~ Annual assessment on health care entities.—

(1) For purposes of this section, the term:

(a) "Board" means the Health Care Cost Containment Board.

(b)1. "Net operating revenue" means gross revenue less deductions from revenue.

2. "Gross revenue" means the sum of daily service charges, ambulatory service charges, ancillary service charges, and other operating revenue, *except revenues received for testing or analyzing samples received from outside the state or from product sales outside the state.*

3. "Deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions, and includes the offset of restricted donations and grants for indigent care.

(2) There is hereby imposed an annual assessment against certain health care entities as described in this section:

(a) The assessment shall be equal to 1.5 percent of the annual net operating revenues of health care entities.

1. The first assessment shall be due on April 30, 1992, and the second on April 30, 1993, and each shall be based on the appropriate reports filed with the board no later than March 31 of the year the assessment is due. By January 1, 1992, the health care entity shall make a one-time election to base the assessments on net operating revenue received in the health care entity's latest fiscal year ending on or before December 31, 1991, or December 31, 1992, respectively, or in the 12-month period ending March 31 of the year the assessment is due. The assessment shall be payable to and collected by the board.

2. Beginning July 1, 1993, assessments shall be based on annual net operating revenues for the entity's most recently completed fiscal year as provided in subsection (3).

(b) For the purpose of this section, "health care entities" include the following:

1. Ambulatory surgical centers licensed under s. 395.003.

2. Clinical laboratories licensed under s. 483.091, excluding any hospital laboratory defined under s. 483.041(7), any clinical laboratory operated by the state or a political subdivision of the state, and any blood, *plasma,* or tissue bank *procuring, storing, or distributing* ~~where the majority of revenues are received from the sale of~~ blood, *plasma,* or tissue *either for further manufacture or research or* ~~and where blood, plasma, or tissue is procured from volunteer donors and donated, processed, stored, or distributed~~ on a nonprofit basis.

3. Freestanding radiation therapy centers providing treatment through the use of radiation therapy machines that are registered under s. 404.22 and ss. 10D-91.902, 10D-91.903, and 10D-91.904 of the Florida Administrative Code.

4. Diagnostic imaging centers that are freestanding outpatient facilities that provide specialized services for the identification or determination of a disease through examination and also provide sophisticated radiological services such as computed tomography scans and magnetic resonance imaging, and in which services are rendered by a physician licensed by the Board of Medicine under s. 458.311, s. 458.313, or s. 458.317, or by an osteopathic physician licensed by the Board of Osteopathic Medical Examiners under s. 459.006, s. 459.007, or s. 459.0075.

(3)(a) Beginning July 1, 1993, the assessment shall be on the actual experience of the entity as reported to the board within 120 days after the end of its fiscal year in the preceding calendar year based upon reports developed by the board in a rule after consultation with appropriate professional and governmental advisory bodies.

(b) Within 6 months after the end of each entity's fiscal year, the board shall certify the amount of the assessment to each entity. The assessment shall be payable to and collected by the board in equal quarterly amounts on or before the first day of each calendar quarter, beginning with the first full calendar quarter.

(4) All moneys collected pursuant to this section shall be deposited into the Public Medical Assistance Trust Fund.

(5) The board may use its authority under ss. 407.02, 407.06, and 407.07 in administering this section.

Section 43. Section 395.60, Florida Statutes, is transferred, renumbered as section 395.801, Florida Statutes, and amended to read:

395.801 ~~395.60~~ Short title.—*Sections 395.801-395.804* ~~Effective July 1, 1988, ss. 395.60-395.63 are created and~~ may be cited as the "Medical Education and Tertiary Care Act."

Section 44. Section 395.61, Florida Statutes, is transferred and renumbered as section 395.802, Florida Statutes.

Section 45. Section 395.62, Florida Statutes, is transferred, renumbered as section 395.803, Florida Statutes, and amended to read:

395.803 ~~395.62~~ Medical Education and Tertiary Care Trust Fund.—There is hereby created the Medical Education and Tertiary Care Trust Fund within the Board of Regents, State University System. All moneys deposited into the Medical Education and Tertiary Care Trust Fund shall be allocated as described in *s. 395.804* ~~s. 395.63~~ and expended by the respective hospitals after consultation with the affiliated college of medicine.

Section 46. Section 395.63, Florida Statutes, is transferred and renumbered as section 395.804, Florida Statutes.

Section 47. Sections 395.012, 395.013, 395.0141, 395.0143, and 395.0144, Florida Statutes, and section 395.0146, Florida Statutes, as amended by section 3 of chapter 90-284, Laws of Florida, are repealed.

Section 48. Notwithstanding the provisions of section 4 of chapter 82-125, section 30 of chapter 82-182, section 1 of chapter 85-65, section 52 of chapter 85-175, section 1 of chapter 88-303, section 1 of chapter 89-296, section 1 of chapter 90-192, section 15 of chapter 90-284, or section 6 of chapter 91-201, Laws of Florida, or of the Regulatory Sunset Act or any other provision of law which provides for review and repeal in accordance with section 11.61, Florida Statutes, sections 394.4787(4), 394.4788(2), (3), 395.001, 395.002, 395.003, 395.004, 395.005, 395.006, 395.007, 395.008, 395.009, 395.0101, 395.011, 395.0115, 395.014, 395.0142, 395.01465, 395.015, 395.016, 395.0165, 395.017, 395.0172, 395.0175, 395.018, 395.0185, 395.0201, 395.0205, 395.031, 395.032, 395.033, 395.0335, 395.034, 395.035, 395.036, 395.037, 395.038, 395.041, 395.101, 395.102, 395.103, 395.104, and 395.63, Florida Statutes, shall not expire or stand repealed October 1, 1992, as scheduled by such laws, but those sections, as transferred, renumbered, and amended by this act, are revived and readopted.

Section 49. Paragraph (v) of subsection (3) of section 119.07, Florida Statutes, is amended to read:

119.07 Inspection and examination of records; exemptions.—

(3)

(v) A patient record obtained by the Department of Health and Rehabilitative Services or its agent pursuant to *s. 395.404* ~~s. 395.035~~, which record contains the name, residence or business address, telephone number, social security or other identifying number, or photograph of any person or the spouse, relative, or guardian of such person or which record is patient-specific or otherwise identifies the patient, either directly or indirectly, is exempt from the provisions of subsection (1).

Section 50. Paragraph (b) of subsection (2) of section 240.4067, Florida Statutes, is amended to read:

240.4067 Medical Education Reimbursement and Loan Repayment Program.—

(2) From the funds available, the Department of Health and Rehabilitative Services shall make payments to selected medical professionals as follows:

(b) All payments shall be contingent on continued proof of primary care practice in an area defined in *s. 395.602(2)(f)* ~~s. 395.102(2)(a)~~, or an underserved area designated by the Department of Health and Rehabilitative Services, provided the practitioner accepts Medicaid reimbursement if eligible for such reimbursement. Correctional facilities, state hospitals, and other state institutions that employ medical personnel shall be designated by the Department of Health and Rehabilitative Services as underserved locations. Locations with high incidences of infant mortality, high morbidity, or low Medicaid participation by health care professionals may be designated as underserved.

Section 51. Subsection (1) of section 320.0801, Florida Statutes, is amended to read:

320.0801 Additional license tax on certain vehicles.—

(1) In addition to the license taxes specified in s. 320.08 and in subsection (2), there is hereby levied and imposed an annual license tax of 10 cents for the operation of a motor vehicle, as defined in s. 320.01, and moped, as defined in s. 316.003(77), which tax shall be paid to the department or its agent upon the registration or renewal of registration of the vehicle. Notwithstanding the provisions of s. 320.20, revenues collected from the tax imposed in this subsection shall be deposited in the Emergency Medical Services Trust Fund created in s. 401.34(4) and used solely for the purpose of carrying out the provisions of ss. *395.401, 395.4015, 395.404, and 395.4045* ~~395.031, 395.032, 395.035, and 395.036~~ and s. 11, ch. 87-399, Laws of Florida.

Section 52. Paragraph (a) of subsection (4) of section 322.0602, Florida Statutes, is amended to read:

322.0602 Youthful Drunk Driver Visitation Program.—

(4) VISITATION REQUIREMENT.—

(a) To the extent that personnel and facilities are made available to the court, the court may include a requirement for supervised visitation by the probationer to all, or any, of the following:

1. A trauma center, as defined in *s. 395.401* ~~s. 395.031~~, or a hospital as defined in s. 395.002, which regularly receives victims of vehicle accidents, between the hours of 10 p.m. and 2 a.m. on a Friday or Saturday night, in order to observe appropriate victims of vehicle accidents involving drinking drivers, under the supervision of any of the following:

a. A registered nurse trained in providing emergency trauma care or prehospital advanced life support.

b. An emergency room physician.

c. An emergency medical technician.

2. A treatment resource, as defined in s. 396.032 or s. 397.021, which cares for advanced alcoholics or drug abusers, to observe persons in the terminal stages of alcoholism or drug abuse, under the supervision of appropriately licensed medical personnel. Prior to any visitation of such terminally ill or disabled persons, the persons or their legal representatives must give their express consent to participate in the visitation program.

3. If approved by the county coroner, the county coroner's office or the county morgue to observe appropriate victims of vehicle accidents involving drinking drivers, under the supervision of the coroner or a deputy coroner.

Section 53. Paragraph (h) of subsection (3) of section 381.004, Florida Statutes, is amended to read:

381.004 Testing for human immunodeficiency virus.—

(3) HUMAN IMMUNODEFICIENCY VIRUS TESTING; INFORMED CONSENT; RESULTS; COUNSELING; CONFIDENTIALITY.—

(h) Human immunodeficiency virus test results contained in the medical records of a hospital licensed under chapter 395 may be released in accordance with *s. 395.3025* ~~s. 395.017~~ without being subject to the requirements of subparagraph (f)2., subparagraph (f)9., or paragraph (g); provided the hospital has obtained written informed consent for the HIV test in accordance with provisions of this section.

Section 54. Paragraph (d) of subsection (4) of section 381.026, Florida Statutes, is amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.—

(4) RIGHTS OF PATIENTS.—Each health care facility or provider shall observe the following standards:

(d) Access to health care.—

1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

2. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment~~, as provided in s. 395.0143~~.

Section 55. Paragraph (b) of subsection (3) of section 381.703, Florida Statutes, is amended to read:

381.703 Local and state health planning.—

(3) FUNDING.—

(b)1. A hospital licensed under chapter 395, a nursing home licensed under chapter 400, and an adult congregate living facility licensed under chapter 400 shall be assessed an annual fee based on number of beds.

2. All other facilities and organizations listed in paragraph (a) shall each be assessed an annual fee of $150.

3. Facilities operated by the Department of Health and Rehabilitative Services or the Department of Corrections and any hospital which meets the definition of rural hospital pursuant to *s. 395.602* ~~s. 395.102(2)~~ are exempt from the assessment required in this subsection.

Section 56. Paragraph (h) of subsection (3) of section 381.706, Florida Statutes, is amended to read:

381.706 Projects subject to review.—

(3) EXEMPTIONS.—Upon request, supported by such documentation as the department may require, the department shall grant an exemption from the provisions of subsection (1):

(h) For hospice or home health services provided by a rural hospital, as defined in *s 395 602* ~~s. 395 102~~, or for swing beds in such rural hospital in a number that does not exceed one-half of its licensed beds.

A request for exemption pursuant to this subsection may be made at any time and is not subject to the batching requirements of this section.

Section 57. Subsection (3) of section 383.336, Florida Statutes, is amended to read:

383.336 Provider hospitals; practice parameters; peer review board.—

(3) Each provider hospital shall establish a peer review board consisting of obstetric physicians and other persons having credentials within that hospital to perform deliveries by caesarean section. This board shall review, at least monthly, every caesarean section performed since the previous review and paid for by state funds or federal funds administered by the state. The board shall conduct its review pursuant to the parameters specified in the rule adopted by the Department of Health and Rehabilitative Services pursuant to this act and shall pay particular attention to electronic fetal monitoring records, umbilical cord gas results, and Apgar scores in determining if the caesarean section delivery was appropriate. The results of this periodic review must be shared with the attending physician. These reviews and the resultant reports must be considered a part of the hospital's quality assurance monitoring and peer review process established pursuant to ss. 407.12 and *395.0193* ~~395.0115~~.

Section 58. Paragraphs (b) and (c) of subsection (2) of section 394.463, Florida Statutes, are amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(b) Transportation for involuntary examination.—Each county shall designate a single law enforcement agency within the county, or portions thereof, which shall take a person into custody upon the entry of an ex parte order or the execution of a certificate by an authorized professional and which shall transport that person to the nearest receiving facility for examination. If the law enforcement officer believes that the person is suffering from an emergency medical condition as defined in *s. 395.002* ~~s. 395.0142(2)(c)~~, the person may be transported to a hospital for emergency medical treatment regardless of whether the hospital is a receiving facility designated under this chapter. The law enforcement agency designated for the area in which the person in need of transport for involuntary examination is situated may thereafter decline to transport the person to a receiving facility only if:

1. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service for transportation of persons to receiving facilities pursuant to this section at the sole cost of the county; and

2. The law enforcement agency and transport service agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.

(c) Examination.—A patient who is provided an examination at a receiving facility shall be examined by a physician or clinical psychologist without unnecessary delay and may be given emergency treatment pursuant to s. 394.459(3)(a). The least restrictive form of treatment shall be made available when determined to be necessary by a facility physician or clinical psychologist. Any person for whom involuntary examination has been initiated pursuant to paragraph (a) shall not be released by the receiving facility or its contractor without the documented approval of a person who is qualified under the provisions of this chapter to initiate an involuntary examination. However, a patient may be detained at a receiving facility for involuntary examination no longer than 72 hours. A person who is being involuntarily examined under paragraph (a) and is being evaluated or treated at a hospital for an emergency medical condition specified in *s 395 002* ~~s. 395.0142~~ must be examined within 72 hours. The 72-hour period begins when the patient arrives at the hospital *and*, ceases when the attending physician documents that the patient has an emergency medical condition~~, and resumes after the attending physician has documented that the patient is stabilized and that the emergency medical condition is alleviated. If the hospital is not a designated receiving facility,~~ One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized ~~and appropriate medical treatment is available at the designated receiving facility to which the patient is being transferred~~ or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or

2. The patient must be transferred to a designated receiving facility *in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.*

Section 59. Subsection (8) of section 394 4787, Florida Statutes, is amended to read:

394.4787 Definitions.—As used in this act:

(8) "Specialty psychiatric hospital" means a hospital licensed by the department pursuant to *s. 395.002(26)* ~~s. 395.002(14)(b)~~ as a specialty psychiatric hospital.

Section 60. Subsection (1) of section 394.4789, Florida Statutes, is amended to read:

394.4789 Establishment of referral process and eligibility determination.—

(1) The department shall adopt by rule a referral process which shall provide each participating specialty psychiatric hospital with a system for accepting into the hospital's care indigent mentally ill persons referred by the department. It is the intent of the Legislature that a hospital which seeks payment under s. 394.4788 shall accept referrals from the department. However, a hospital shall have the right to refuse the admission of a patient due to lack of functional bed space or lack of services appropriate to a patient's specific treatment and no hospital shall be required to accept referrals if the costs for treating the referred patient are no longer reimbursable because the hospital has reached the level of contribution made to the PMATF in the previous fiscal year. Furthermore, a hospital that does not seek compensation for indigent mentally ill patients under the provisions of this act shall not be obliged to accept department referrals, notwithstanding any agreements it may have entered into with the department. The right of refusal in this subsection shall not affect a hospital's requirement to provide emergency care pursuant to *s. 395.1041* ~~s. 395.0142~~ or other statutory requirements related to the provision of emergency care.

Section 61. Subsection (1) of section 401.425, Florida Statutes, is amended to read:

401.425 Emergency medical services quality assurance; immunity from liability.—

(1) As used in this section, the term "emergency medical review committee" or "committee" means a committee of:

(a) An emergency medical service provider, a local *trauma agency* or regional trauma agency as *defined* ~~provided~~ in *s. 395.401* ~~s. 395.031~~, a quality assurance committee as provided in s. 401.265, or a local emergency medical services advisory council;

(b) A hospital licensed under chapter 395 which is directly responsible for a licensed emergency medical service provider; or

(c) The department, or employees, agents, or consultants of the department.

Section 62. Paragraph (c) of subsection (4) of section 401.48, Florida Statutes, is amended to read:

401.48 Air ambulance service; licensure.—

(4)

(c) Unless, in the opinion of the attending physician, the patient has an emergency medical condition as defined by *s. 395.002* ~~s. 395.0142(2)(c)~~, the service must provide each person using the service, before rendering the service, a written description of the services to be rendered and the cost of such services.

Section 63. The amendment to section 401.48, Florida Statutes, by this act shall not take effect unless the expiration of section 401.48, Florida Statutes, by section 13 of chapter 83-196, Laws of Florida, is abrogated on or before October 1, 1992.

Section 64. Subsections (7) and (13) of section 407.002, Florida Statutes, are amended to read:

407.002 Definitions.—As used in this act, the term:

(7) "Comprehensive rehabilitative hospital" or "rehabilitative hospital" means a hospital licensed by the Department of Health and Rehabilitative Services as a specialty hospital, as that term is defined in s. 395.002~~(14)~~; provided that the hospital provides a program of comprehensive medical rehabilitative services and is designed, equipped, organized, and operated solely to deliver comprehensive medical rehabilitative services, and further provided that all licensed beds in the hospital are classified as "comprehensive rehabilitative beds" pursuant to *s. 395.0045* ~~s. 395.003(4)~~, and are not classified as "general beds."

(13) "Hospital" *has the same meaning as that term is* ~~means a health care institution as~~ defined in s. 395.002*(12)*~~(6)~~.

Section 65. The amendment to section 407.002, Florida Statutes, by this act shall not take effect unless the repeal of section 407.002, Florida Statutes, by section 34 of chapter 88-394, Laws of Florida, is abrogated on or before October 1, 1992.

Section 66. Subsection (2) of section 407.51, Florida Statutes, is amended to read:

407.51 Exceeding approved budget or previous year's actual experience by more than maximum rate of increase; allowing or authorizing operating revenue or expenditures to exceed amount in approved budget; penalties.—

(2) Penalties shall be assessed as follows:

(a) For the first occurrence within a 5-year period, the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 5 percent; and, if such excess is greater than 5 percent over the maximum allowable rate of increase, any amount in excess of 5 percent shall be levied by the board as a fine against such hospital to be deposited in the Public Medical Assistance Trust Fund.

(b) For the second occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 2 percent; and, if such excess is greater than 2 percent over the maximum allowable rate of increase, any amount in excess of 2 percent shall be levied by the board as a fine against such hospital to be deposited in the Public Medical Assistance Trust Fund.

(c) For the third occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall:

1. Levy a fine against the hospital in the total amount of the excess to be deposited in the Public Medical Assistance Trust Fund.

2. Notify the Department of Health and Rehabilitative Services of the violation, whereupon the department shall not accept any application for a certificate of need pursuant to ss. 381.701-381.7155 from or on behalf of such hospital until such time as the hospital has demonstrated to the satisfaction of the board that, following the date the penalty was imposed under subparagraph 1., the hospital has stayed within its projected or amended budget or its applicable maximum allowable rate of increase for a period of at least 1 year. However, this provision does not apply with respect to a certificate-of-need application filed to satisfy a life or safety code violation.

3. Upon a determination that the hospital knowingly and willfully generated such excess, notify the Department of Health and Rehabilitative Services, whereupon the department shall initiate disciplinary proceedings to deny, modify, suspend, or revoke the license of such hospital or impose an administrative fine on such hospital not to exceed $20,000.

The determination of the amount of any such excess shall be based upon net revenues per adjusted admission excluding funds distributed to the hospital from the Public Medical Assistance Trust Fund. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to *s. 395.701* ~~s. 395.101~~ minus the amount of revenues received by the hospital through the Public Medical Assistance Trust Fund. It is the responsibility of the hospital to demonstrate to the satisfaction of the board its entitlement to such reduction. It is the intent of the Legislature that the Health Care Cost Containment Board, in levying any penalty imposed against a hospital for exceeding its maximum allowable rate of increase or its approved budget pursuant to this subsection, consider the effect of changes in the case mix of the hospital. It is the responsibility of the hospital to demonstrate to the satisfaction of the board any change in its case mix. For psychiatric hospitals, the board shall also reduce the amount of excess by utilizing as a proxy for case mix the change in a hospital's audited actual average length of stay as compared to the previous year's audited actual average length of stay without any thresholds or limitations.

Section 67. The amendment to section 407.51, Florida Statutes, by this act shall not take effect unless the repeal of section 407.51, Florida Statutes, by section 34 of chapter 88-394, Laws of Florida, is abrogated on or before October 1, 1992.

Section 68. Subsection (1) of section 409.918, Florida Statutes, is amended to read:

409.918 Public Medical Assistance Trust Fund.—It is declared that access to adequate health care is a right which should be available to all Floridians. However, rapidly increasing health care costs threaten to make such care unaffordable for many citizens. The Legislature finds that unreimbursed health care services provided to persons who are unable to pay for such services cause the cost of services to paying patients to increase in a manner unrelated to the actual cost of services delivered. Further, the Legislature finds that inequities between hospitals in the provision of unreimbursed services prevent hospitals that provide the bulk of such services from competing on an equitable economic basis with hospitals that provide relatively little care to indigent persons. Therefore, it is the intent of the Legislature to provide a method for funding the provision of health care services to indigent persons, the cost of which shall be borne by the state and by hospitals that are granted the privilege of operating in this state.

(1) All moneys collected pursuant to *s. 395.701* ~~s. 395.101~~ shall be deposited into the Public Medical Assistance Trust Fund, which is hereby created.

Section 69. Subsection (3) of section 427.708, Florida Statutes, is amended to read:

427.708 Certain public safety and health care providers required to purchase and operate TDD's.—

(3) Each hospital as defined in s. 395.002~~(6)~~ shall purchase and continually operate at least one TDD.

Section 70. Subsection (5) of section 440.185, Florida Statutes, is amended to read:

440.185 Notice of injury or death; reports; penalties for violations.—

(5) Additional reports with respect to such injury and of the condition of such employee, including copies of medical reports, shall be sent by the employer or carrier to the division at such times and in such manner as the division may prescribe. In carrying out its responsibilities under this chapter, the division may by rule provide for the obtaining of any medical records relating to medical treatment provided pursuant to this chapter, notwithstanding the provisions of ss. 90.503, *395.3025(4)* ~~395.017(3)~~, and 396.112.

Section 71. Subsections (7) and (9) of section 458.331, Florida Statutes, are amended to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(7) Upon the department's receipt from the Department of Health and Rehabilitative Services pursuant to *s. 395.0197* ~~s. 395.041~~ of the name of a physician whose conduct may constitute grounds for disciplinary action by the department, the department shall investigate the occurrences upon which the report was based and determine if action by the department against the physician is warranted.

(9) When an investigation of a physician is undertaken, the department shall promptly furnish to the physician or his attorney a copy of the complaint or document which resulted in the initiation of the investigation. For purposes of this subsection, such documents include, but are not limited to: the pertinent portions of *an annual* ~~a quarterly~~ report submitted to the department pursuant to *s. 395.0197(5)(b)* ~~s. 395.041(5)(b)~~; a report of an adverse or untoward incident which is provided to the department pursuant to the provisions of *s. 395.0197(6)* ~~s. 395.041(6)~~; a report of peer review disciplinary action submitted to the department pursuant to the provisions of *s. 395.0193(4)* ~~s. 395.0115(4)~~ or s. 458.337, providing that the investigations, proceedings, and records relating to such peer review disciplinary action shall continue to retain their privileged status even as to the licensee who is the subject of the investigation, as provided by ss. *395.0193(7)* ~~395.0115(7)~~ and 458.337(3); a report of a closed claim submitted pursuant to s. 627.912; a presuit notice submitted pursuant to s. 766.106(2); and a petition brought under the Florida Birth-Related Neurological Injury Compensation Plan, pursuant to s. 766.305(2). The physician may submit a written response to the information contained in the complaint or document which resulted in the initiation of the investigation within 45 days after service to the physician of the complaint or document. The physician's written response shall be considered by the probable cause panel.

Section 72. Subsections (7) and (9) of section 459.015, Florida Statutes, are amended to read:

459.015 Grounds for disciplinary action by the board.—

(7) Upon the department's receipt from the Department of Health and Rehabilitative Services pursuant to *s. 395.0197* ~~s. 395.041~~ of the name of an osteopathic physician whose conduct may constitute grounds for disciplinary action by the department, the department shall investigate the occurrences upon which the report was based and determine if action by the department against the osteopathic physician is warranted.

(9) When an investigation of an osteopathic physician is undertaken, the department shall promptly furnish to the osteopathic physician or his attorney a copy of the complaint or document which resulted in the initiation of the investigation. For purposes of this subsection, such documents include, but are not limited to: the pertinent portions of *an annual* ~~a quarterly~~ report submitted to the department pursuant to *s. 395.0197(5)(b)* ~~s. 395.041(5)(b)~~; a report of an adverse or untoward inci-

dent which is provided to the department pursuant to the provisions of *s. 395.0197(6)* ~~s. 395.041(6)~~; a report of peer review disciplinary action submitted to the department pursuant to the provisions of *s. 395.0193(4)* ~~s. 395.0115(4)~~ or s. 459.016, provided that the investigations, proceedings, and records relating to such peer review disciplinary action shall continue to retain their privileged status even as to the licensee who is the subject of the investigation, as provided by ss. *395.0193(7)* ~~395.0115(7)~~ and 459.016(3); a report of a closed claim submitted pursuant to s. 627.912; a presuit notice submitted pursuant to s. 766.106(2); and a petition brought under the Florida Birth-Related Neurological Injury Compensation Plan, pursuant to s. 766.305(2). The osteopathic physician may submit a written response to the information contained in the complaint or document which resulted in the initiation of the investigation within 45 days after service to the osteopathic physician of the complaint or document. The osteopathic physician's written response shall be considered by the probable cause panel.

Section 73. Paragraph (b) of subsection (5) of section 461.013, Florida Statutes, is amended to read:

461.013 Grounds for disciplinary action; action by the board; investigations by department.—

(5)

(b) Upon the department's receipt from the Department of Health and Rehabilitative Services pursuant to *s. 395.0197* ~~s. 395.041~~ of the name of the podiatrist whose conduct may constitute grounds for disciplinary action by the department, the department shall investigate the occurrences upon which the report was based and determine if action by the department against the podiatrist is warranted.

Section 74. Subsection (1) of section 468.505, Florida Statutes, is amended to read:

468.505 Exemptions; exceptions.—

(1) Sections 468.501-468.518 shall not be construed as prohibiting or restricting the practice, services, or activities of:

(a) A person licensed in this state under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, chapter 480, chapter 490, or chapter 491, when engaging in the profession or occupation for which he is licensed, or of any person employed by and under the supervision of the licensee when rendering services within the scope of the profession or occupation of the licensee;

(b) A person employed as a dietitian by the government of the United States, if the person engages in dietetics solely under direction or control of the organization by which the person is employed;

(c) A person employed as a cooperative extension home economist;

(d) A person pursuing a course of study leading to a degree in dietetics and nutrition from a program or school accredited pursuant to s. 468.509(2), if the activities and services constitute a part of a supervised course of study, and if the person is designated by a title that clearly indicates the person's status as a student or trainee;

(e) A person fulfilling the supervised experience component of s. 468.509, if the activities and services constitute a part of the experience necessary to meet the requirements of s. 468.509;

(f) Any dietitian or nutritionist from another state practicing dietetics or nutrition incidental to a course of study when taking or giving a postgraduate course or other course of study in this state, provided such dietitian or nutritionist is licensed in another jurisdiction or is a registered dietitian or holds an appointment on the faculty of a school accredited pursuant to s. 468.509(2);

(g) A person who markets or distributes food, food materials, or dietary supplements, or any person who engages in the explanation of the use and benefits of those products or the preparation of those products, if that person does not engage for a fee in dietetics and nutrition practice as defined in this act;

(h) A person who markets or distributes food, food materials, or dietary supplements, or any person who engages in the explanation of the use of those products or the preparation of those products as an employee of an establishment permitted pursuant to chapter 465;

(i) An educator who is in the employ of a nonprofit organization approved by the council; a federal, state, county, or municipal agency, or other political subdivision; an elementary or secondary school; or an accredited institution of higher education the definition of which, as provided in s. 468.509(2), applies to other sections of this act, insofar as the activities and services of the educator are part of such employment;

(j) Any person who provides weight control services or related weight control products, provided the program has been reviewed by, consultation is available from, and no program change can be initiated without prior approval by a licensed dietitian/nutritionist, a dietitian or nutritionist licensed in another state that has licensure requirements considered by the council to be at least as stringent as the requirements for licensure under this act, or a registered dietitian;

(k) A person employed by a hospital licensed under chapter 395, or by a nursing home or adult congregate living facility licensed under part I or part II of chapter 400, or by a continuing care facility certified under chapter 651, if the person is employed in compliance with the laws and rules adopted thereunder regarding the operation of its dietetic department;

(l) A person employed by a nursing facility exempt from licensing under *s. 395.002(12)* ~~s. 395.002(6)~~, or a person exempt from licensing under s. 464.022; or

(m) A person employed as a dietetic technician.

Section 75. Section 626.941, Florida Statutes, is amended to read:

626.941 Purpose.—The Legislature finds that control and prevention of medical accidents and injuries is a significant public health and safety concern. An essential method of controlling medical injuries is a comprehensive program of risk management, as required by *s. 395.0197* ~~s. 395.041~~. The key to such a program is a competent and qualified health care risk manager. It is the intent of the Legislature to establish certain minimum standards for health care risk managers to ensure the public welfare.

Section 76. Subsection (7) of section 626.943, Florida Statutes, is amended to read:

626.943 Powers and duties of the department.—It is the function of the department to:

(7) Develop a model risk management program for health care facilities which will satisfy the requirements of *s. 395.0197* ~~s. 395.041~~.

Section 77. Subsection (1) of section 627.912, Florida Statutes, is amended to read:

627.912 Professional liability claims and actions; reports by insurers.—

(1) Each self-insurer authorized under s. 627.356 or s. 627.357 and each insurer or joint underwriting association providing professional liability insurance to a practitioner of medicine licensed pursuant to the provisions of chapter 458, to a practitioner of osteopathic medicine licensed pursuant to the provisions of chapter 459, to a podiatrist licensed pursuant to the provisions of chapter 461, to a dentist licensed pursuant to the provisions of chapter 466, to a hospital licensed pursuant to the provisions of chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, to an ambulatory surgical center as defined in s. 395.002~~(2)~~, or to a member of The Florida Bar shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

(a) A final judgment in any amount.

(b) A settlement in any amount.

(c) A final disposition not resulting in payment on behalf of the insured.

Reports shall be filed with the department and, if the insured party is licensed pursuant to chapter 458, chapter 459, chapter 461, or chapter 466, with the Department of Professional Regulation, no later than 60 days following the occurrence of any event listed in paragraph (a), para-

graph (b), or paragraph (c). The Department of Professional Regulation shall review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. The Department of Professional Regulation, as part of the annual report required by s. 455.2285, shall publish annual statistics, without identifying licensees, on the reports it receives, including final action taken on such reports by the Department of Professional Regulation or the appropriate regulatory board.

Section 78. The amendment to section 627.912, Florida Statutes, by this act shall not take effect unless the expiration of section 627.912, Florida Statutes, by section 809(2nd) of chapter 82-243, Laws of Florida, is abrogated on or before October 1, 1992.

Section 79. Section 641.55, Florida Statutes, is amended to read:

641.55 Internal risk management program.—

(1) Every health maintenance organization certified under this part shall, as a part of its administrative functions, establish an internal risk management program which shall include the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients;

(b) The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, including risk management and risk prevention education and training of all nonphysician personnel as follows:

1. Such education and training of all nonphysician personnel as part of their initial orientation; and

2. At least 1 hour of such education and training annually for all nonphysician personnel of the health maintenance organization who work in clinical areas and provide patient care;

(c) The analysis of patient grievances which relate to patient care and the quality of medical services; and

(d) The development and implementation of an incident reporting system based upon the affirmative duty of all providers and all agents and employees of the health maintenance organization to report injuries and adverse incidents to the risk manager.

(2) The risk management program shall be the responsibility of the governing authority or board of the health maintenance organization. Every health maintenance organization which has an annual premium volume of $10 million or more and which directly provides health care in a building owned or leased by the health maintenance organization shall hire a risk manager, certified under ss. 626.941-626.945, who shall be responsible for implementation of the organization's risk management program required by this section. A part-time risk manager shall not be responsible for risk management programs in more than four organizations or facilities. Every health maintenance organization which does not directly provide health care in a building owned or leased by the health maintenance organization and every health maintenance organization with an annual premium volume of less than $10 million shall designate an officer or employee of the health maintenance organization to serve as the risk manager.

(3) In addition to the programs mandated by this section, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims shall be encouraged and their implementation and operation facilitated. Additional approaches may include extending risk management programs to provider offices or facilities.

(4) The Department of Health and Rehabilitative Services shall, after consulting with the Department of Insurance, promulgate rules necessary to carry out the provisions of this section, including rules governing the establishment of required internal risk management programs to meet the needs of individual establishments. The Department of Insurance shall assist the Department of Health and Rehabilitative Services in preparing these rules. Each internal risk management program shall include the use of incident reports to be filed with the risk manager. The risk manager shall have free access to all health maintenance organization or provider medical records. The incident reports shall be considered to be a part of the workpapers of the attorney defending the establishment in litigation relating thereto and shall be subject to discovery, but not be admissible as evidence in court, nor shall any person filing an incident report be subject to civil suit by virtue of the incident report and the matters it contains. As a part of each internal risk management program, the incident reports shall be utilized to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct these problem areas.

(5)(a) Each health maintenance organization subject to this section shall submit an annual report to the Department of Health and Rehabilitative Services summarizing the incident reports that have been filed in the health maintenance organization for that year pertaining to services rendered on the premises of the health maintenance organization. The report shall be on a form prescribed by rule of the Department of Health and Rehabilitative Services and shall include with respect to medical services rendered on the premises of the health maintenance organization:

1. The total number of adverse incidents causing injury to patients.

2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries and the number of incidents occurring within each category.

3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.

4. The name of each provider or a code number utilizing the health care professional's license number and a separate code number identifying all other individuals directly involved in adverse incidents causing injury to patients, the relationship of the individual or provider to the health maintenance organization, and the number of incidents in which each individual or provider has been directly involved. Each health maintenance organization shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.

5. A description of all medical malpractice claims filed against the health maintenance organization or its providers, including the total number of pending and closed claims and the nature of the incident which led to, the persons involved in, and the status and disposition of each claim. Each report shall update status and disposition for all prior reports.

6. A report of all disciplinary actions taken against any provider or any medical staff member of the health maintenance organization, including the nature and cause of the action.

(b) The information reported to the department pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall also be reported to the Department of Professional Regulation quarterly. The Department of Professional Regulation shall review the information and determine whether any of the incidents potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(c) The annual report shall also contain the name of the risk manager of the health maintenance organization, a copy of its policy and procedures which govern the measures taken by the organization and its risk manager to reduce the risk of injuries and adverse or untoward incidents, and the results of these measures. This report and the quarterly reports under paragraph (b) shall be held confidential and shall not be available to the public pursuant to s. 119.07 or any other law providing access to public records, nor shall the report be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the department, the Department of Professional Regulation, and the appropriate regulatory board. This report shall not be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department, the Department of Professional Regulation, or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause.

(6) If an adverse or untoward incident, whether occurring in the facilities of the health maintenance organization or arising from health care prior to admission to the facilities of the organization or in the facility of one of its providers, results in:

(a) The death of a patient;

(b) Severe brain or spinal damage to a patient;

(c) A surgical procedure being performed on the wrong patient; or

(d) A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient,

the organization shall report this incident to the Department of Health and Rehabilitative Services within 3 working days of its occurrence. A more detailed followup report shall be submitted to the Department of Health and Rehabilitative Services within 10 days after the first report. The department may require an additional, final report. Reports under this subsection shall be sent immediately by the department to the Department of Professional Regulation whenever they involve a health care provider licensed under chapter 458, chapter 459, chapter 461, or chapter 466. These reports shall not be available to the public pursuant to s. 119.07 or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the department, the Department of Professional Regulation, and the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department, the Department of Professional Regulation, or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The Department of Health and Rehabilitative Services may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken by the health maintenance organization in response to the incident. The Department of Professional Regulation shall review each incident and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(7) In addition to any penalty imposed pursuant to s. 641.52, the department may, beginning July 1, 1989, impose an administrative fine, not to exceed $5,000, for any violation of the reporting requirements of subsection (5) or subsection (6).

(8) The department and, upon subpoena issued pursuant to s. 455.223, the Department of Professional Regulation shall have access to all health maintenance organization records necessary to carry out the provisions of this section. The records obtained are not available to public access, nor are they discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the department, the Department of Professional Regulation, and the appropriate regulatory board; nor may records obtained pursuant to s. 455.223 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records that form the basis of the determination of probable cause, except that, with respect to medical review committee records, the provisions of s. 766.101 control.

(9) The department shall review, no less frequently than annually, the risk management program of each health maintenance organization regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents under subsections (5) and (6).

(10) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager certified under part IX of chapter 626 for the implementation and oversight of the risk management program in a health maintenance organization authorized under this chapter for any act or proceeding undertaken or performed within the scope of the function of such risk management program if the risk manager acts without intentional fraud.

(11) If the department, through its receipt of the annual reports prescribed in subsection (5) or through any investigation, has a reasonable belief that conduct by a provider, staff member, or employee of a health maintenance organization may constitute grounds for disciplinary action by the appropriate regulatory board, the department shall report this fact to the regulatory board.

(12) The department shall send information bulletins to all health maintenance organizations as necessary to disseminate trends and preventive data derived from its actions under this section or under *s. 395.0197* ~~s. 395.041~~. The gross data compiled pursuant to this section or *s. 395.0197* ~~s. 395.041~~ shall be furnished by the department upon request to health maintenance organizations to be utilized for risk management purposes. The department may promulgate rules necessary to carry out the provisions of this section.

Section 80. Subsection (8) of section 766.101, Florida Statutes, is amended to read:

766.101 Medical review committee, immunity from liability.—

(8) No cause of action of any nature by a person licensed pursuant to chapter 458, chapter 459, chapter 461, chapter 464, chapter 465, or chapter 466 shall arise against another person licensed pursuant to chapter 458, chapter 459, chapter 461, chapter 464, chapter 465, or chapter 466 for furnishing information to a duly appointed medical review committee, to an internal risk management program established under *s. 395.0197* ~~s. 395.041~~, to the Department of Professional Regulation, or to the appropriate regulatory board if the information furnished concerns patient care at a facility licensed pursuant to part I of chapter 395 where both persons provide health care services, if the information is not intentionally fraudulent, and if the information is within the scope of the functions of the committee, department, or board. However, if such information is otherwise available from original sources, it is not immune from discovery or use in a civil action merely because it was presented during a proceeding of the committee, department, or board.

Section 81. Subsection (1) of section 766.110, Florida Statutes, is amended to read:

766.110 Liability of health care facilities.—

(1) All health care facilities, including hospitals and ambulatory surgical centers, as defined in chapter 395, have a duty to assure comprehensive risk management and the competence of their medical staff and personnel through careful selection and review, and are liable for a failure to exercise due care in fulfilling these duties. These duties shall include, but not be limited to:

(a) The adoption of written procedures for the selection of staff members and a periodic review of the medical care and treatment rendered to patients by each member of the medical staff;

(b) The adoption of a comprehensive risk management program which fully complies with the substantive requirements of *s. 395.0197* ~~s. 395.041~~ as appropriate to such hospital's size, location, scope of services, physical configuration, and similar relevant factors;

(c) The initiation and diligent administration of the medical review and risk management processes established in paragraphs (a) and (b) including the supervision of the medical staff and hospital personnel to the extent necessary to ensure that such medical review and risk management processes are being diligently carried out.

Each such facility shall be liable for a failure to exercise due care in fulfilling one or more of these duties when such failure is a proximate cause of injury to a patient.

Section 82. Paragraph (c) of subsection (6) of section 766.314, Florida Statutes, is amended to read:

766.314 Assessments; plan of operation.—

(6)

(c) The Department of Health and Rehabilitative Services shall, upon notification by the association that an assessment has not been timely paid, enforce collection of such assessments required to be paid by hospitals pursuant to ss. 766.301-766.316. Failure of a hospital to pay such assessment is grounds for disciplinary action pursuant to *s. 395.1065* ~~s. 395.018~~ notwithstanding any provision of law to the contrary.

Section 83. Section 154.235, Florida Statutes, is amended to read:

154.235 Refunding bonds.—

(1) The authority is hereby authorized to provide for the issuance of revenue bonds for the purpose of refunding any ~~of its~~ revenue bonds *or other debt obligations issued in connection with a project and* then outstanding, including the payment of any redemption premium thereon and any interest accrued or to accrue to the earliest or subsequent date of redemption, purchase, or maturity of such revenue bonds *or other debt obligations.*

(2) The proceeds of any such revenue bonds issued for the purpose of refunding outstanding revenue bonds *or other debt obligations* may, in the discretion of the authority, be applied to the purchase or retirement at maturity or redemption of such outstanding revenue bonds *or other debt obligations* either on their earliest or any subsequent redemption date, or upon the purchase or at the maturity thereof, and may, pending such application, be placed in escrow to be applied to such purchase or retirement at maturity or redemption on such date as may be determined by the authority.

(3) Any such escrowed proceeds, pending such use, may be invested and reinvested in direct obligations of the United States, in any obligations of which the principal and interest are unconditionally guaranteed by the United States, in certificates of deposit or time deposits secured by direct obligations of the United States, or in any obligations of which the principal and interest are unconditionally guaranteed by the United States, maturing at such time or times as shall be appropriate to assure the prompt payment, as to principal, interest, and redemption premium, if any, of the outstanding revenue bonds *or other debt obligations* to be so refunded. The interest, income, and profits, if any, earned or realized on any such investment may also be applied to the payment of the outstanding revenue bonds *or other debt obligations* to be so refunded. After the terms of the escrow have been fully satisfied and carried out, any balance of such proceeds and interest, income, and profits, if any, earned or realized on the investments thereof may be returned to the authority for use by it in any lawful manner.

(4) All such revenue bonds issued for the purposes of refunding shall be subject to the provisions of this part in the same manner and to the same extent as other revenue bonds issued pursuant to this part.

Section 84. Section 154.331, Florida Statutes, is amended to read:

154.331 County health and mental health care special districts.—Each county may establish a dependent special district pursuant to the provisions of chapter 125 or, by ordinance, create an independent special district as defined in s. 200.001(8)(e) to provide funding for indigent and other health and mental health care services throughout the county in accordance with this section. The county governing body shall obtain approval, by a majority vote of the electors, to establish the district with authority to annually levy ad valorem taxes which shall not exceed the maximum millage rate authorized by this section. Any independent health or mental health care special district created by this section shall be required to levy and fix millage subject to the provisions of s. 200.065. Once approved by the electorate, the independent health or mental health care special district shall not be required to seek approval of the electorate in future years to levy the previously approved millage*; however, the ordinance establishing the district may provide that the district will cease to exist after a stated period of years unless the county governing body obtains subsequent voter approval to continue the district for the same stated period of time.*

(1) The county governing body shall appoint a district health or mental health care board to serve as the governing board of the independent special district. Such board shall consist of not less than five members, of which two members shall be appointed to the board by the Governor, and not less than three members shall be appointed by the governing body of the county. All members shall have been residents of the county for the previous 12-month period. The members' terms shall be staggered and may not exceed 4 years. No member shall serve for more than two consecutive terms. The governing body of the county shall fill any vacancies that may occur during the term of any board member. Board members may be removed for cause only by the Governor or by a majority of the electors voting within the county.

(2)(a) Each district health or mental health care board may, subject to the limitations placed on the district by the governing body of the county at the time the independent special district was created and approved by the electorate, have any or all of the following powers or functions:

1. To provide and maintain in the county such health or mental health care clinics as the board determines are needed for the general welfare of the county.

2. To provide for the health or mental health care of indigents and to provide such other health or mental health-related services for indigents, including the purchase of institutional services from any private or publicly owned medical facility, as the board determines are needed for the general welfare of the county.

3. To allocate and provide funds for other agencies or facilities in the county which provide health or mental health benefits or health or mental health services that improve the general welfare of indigents and other county residents.

4. To collect information and statistical data that will be helpful to the board and the county in deciding the health or mental health care needs in the county.

5. To consult and coordinate with other agencies dedicated to health or mental health care to the end that the overlapping of services will be prevented.

6. To govern, operate, administer, and fund, or any combination thereof, any county-owned or county-operated medical or mental health facility which is a major provider of charitable health or mental health care services for low-income persons.

7. To assume funding for the county's share of state or federal indigent health or mental health care programs which require financial participation by the county.

8. To lease or buy such real property and personal property and to construct such buildings as are needed to execute the foregoing powers or functions; however, such purchases may not be made or construction done unless paid for with cash on hand or secured by funds deposited in financial institutions. Nothing in this paragraph shall be construed to authorize an independent health or mental health care special district to issue bonds of any nature, nor shall it have the power to require the imposition of any bond by the governing body of the county.

9. To employ, pay, and provide benefits for any part-time or full-time personnel needed to execute the foregoing powers and functions.

(b) Each district health or mental health care board shall:

1. Organize immediately after the members are appointed to elect one of its members as chairman and one of its members as vice chairman, and elect other officers as deemed necessary by the board.

2. Make and adopt bylaws and rules and regulations for the board's guidance, operation, governance, and maintenance, provided such rules and regulations are not inconsistent with federal or state laws or ordinances of the county.

(c) Board members shall serve without compensation, but shall be entitled to necessary expenses incurred in the discharge of their duties.

(d) All financial records and accounts relating to the independent health or mental health care special district shall be available for review by the county governing body and for audit by state auditors assigned from time to time to audit the affairs of the county officials.

(3)(a) The fiscal year of the district must be the same as that of the county.

(b) On or before May 1 of each year, the district health or mental health care board shall prepare a tentative annual written budget of the district's expected income and expenditures, including a contingency fund, and shall compute a proposed millage rate within the voter-approved cap necessary to fund the tentative budget. Prior to adopting a final budget, the board shall comply with the provisions of s. 200.065, relating to the method of fixing millage, and shall fix the final millage rate by ordinance or resolution of the board. The adopted budget and final millage rate must be certified and delivered to the county governing body no later than the time of adoption of the county's annual budget. Included in each certified budget must be the millage rate adopted by ordinance or resolution of the independent health or mental health care special district board as necessary to be applied to raise the funds budgeted for district operations and expenditures. In no circumstances, however, shall any independent health or mental health care special district levy millage to exceed a maximum of 5 mills of assessed valuation of all properties within the county which are subject to ad valorem taxes or the amount approved by the electorate when the district was created, whichever is less. The budget of the district so certified and delivered to the county governing body may not be changed or modified by the county governing body or by any other authority.

(c) All tax moneys collected under this section, as soon after the collection thereof as is reasonably practicable, must be paid directly to the district health or mental health care board by the tax collector of the county, or by the clerk of the circuit court if the clerk collects delinquent taxes.

1. The moneys so received by the district health or mental health care board must be deposited in financial institutions with separate and distinguishable accounts established specifically for the district and may be withdrawn only by checks signed by the chairman of the district health or mental health care board and countersigned by either one other member of the district health or mental health care board or by a chief executive officer who is so authorized by the board.

2. Upon entering the duties of office, the chairman and the other member of the district health or mental health care board or chief executive officer who signs its checks shall each give a surety bond in the sum of $1,000, which bond must be conditioned that each of them shall faithfully discharge the duties of his office. The premium on said bond may be paid by the special district as part of the expense of the board. No other member of the district health or mental health care board may be required to give bond or other security.

3. No funds of the district may be expended except by check as aforesaid, except expenditures from a petty cash account, which may not at any time exceed $25. All expenditures from petty cash must be recorded on the books and records of the district. No funds of the district, excepting expenditures from petty cash, may be expended without prior approval of the board, in addition to the budgeting thereof.

(d) Within 10 days after the expiration of each quarter-annual period, the district health or mental health care board shall cause to be prepared and filed with the county governing body a financial report, which includes:

1. The total expenditures of the board for the quarter-annual period;

2. The total receipts of the board during the quarter-annual period; and

3. A statement of the funds the board has on hand or deposited with financial institutions at the end of the quarter-annual period.

(4) Any independent health or mental health care special district may be dissolved:

(a) Pursuant to s. 165.051; ~~or~~

(b) By an ordinance that is adopted by the county governing body *and that is* ~~may by ordinance vote to dissolve the independent health or mental health care special district~~ subject to the approval of the electorate; *or*

(c) If the district is established subject to subsequent voter approval, by failure of the voters to approve its continuation in a referendum held within 6 months before the district will cease to exist;

provided, however, the county obligates itself to assume the debts, liabilities, contracts, and outstanding obligations of the district within the total millage available to the county governing body for all county and municipal purposes as provided for under s. 9, Art. VII of the State Constitution.

(5) Any independent health or mental health care special district created under this section shall comply with all other statutory requirements of general application which relate to the filing of any financial reports or compliance reports required under part III of chapter 218, or any other report or documentation required by law.

Section 85. Subsection (9) of section 196.012, Florida Statutes, is amended to read:

196.012 Definitions.—For the purpose of this chapter, the following terms are defined as follows, except where the context clearly indicates otherwise:

(9) "Nursing home," *or* "home for special services," ~~or "home for the aged"~~ means an institution which possesses a valid license under chapter 400 on January 1 of the year for which exemption from ad valorem taxation is requested.

Section 86. The sum of $557,100 is appropriated from the Planning and Evaluation Trust Fund to the Department of Health and Rehabilitative Services, and 12 positions are authorized in that department, to carry out the hospital and ambulatory surgical center licensure provisions of this act.

Section 87. Subsection (13) is added to section 409.912, Florida Statutes, to read:

409.912 Cost-effective purchasing of health care.—The department shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The department shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies designed to facilitate the cost-effective purchase of a case-managed continuum of care. The department shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

(13)(a) The department is directed to conduct a comprehensive evaluation of the primary care case management program in districts 5 and 6 known as MediPass and report its findings to the Legislature on or before December 31, 1993. The evaluation shall include but not be limited to an assessment of the program's impact on quality of care, access to Medicaid services, and cost effectiveness. It is the intent of the Legislature that the department apply for a federal freedom-of-choice waiver and any other federal waivers necessary to expand MediPass to five additional districts by December 31, 1994, and to the remaining districts in the state by December 31, 1995, subject to evaluation findings that the program is cost effective, provides quality health care, and improves access to health services. Provided that the programs authorized by this subsection shall not affect the selection of hospitals or impair the patient's freedom of choice as to hospitals providing hospital services. The department shall give first priority to County Public Health Units as defined in chapter 154, Florida Statutes, to develop such managed care programs.

Section 88. In order to evaluate the effectiveness of alternative strategies for reducing Medicaid inpatient hospital expenditures, the Department of Health and Rehabilitative Services shall apply for a federal waiver to implement a competitive bidding demonstration project for Medicaid inpatient hospital services by January 1, 1993. The project shall be designed to be cost effective and shall not increase Medicaid expenditures in the aggregate for inpatient hospital services and administration. The project shall be in such district as determined by the Department of Health and Rehabilitative Services where competitive bidding is most feasible based upon an analysis of client demographics and the supply of inpatient and outpatient hospital services. In awarding contracts to hospitals, the department shall consider:

1. A hospital's percentage of charity care;

2. Graduate medical education costs;

3. A hospital's participation in other state and local programs;

4. Access to hospital services by Medicaid recipients, charity care patients, and other paying patients; and

5. Price.

The department shall report to the Legislature on the implementation of the competitive bidding project on or before December 31, 1993.

(b) The department shall conduct an evaluation of the competitive bidding demonstration project and report its findings to the Legislature on or before December 31, 1995. The evaluation shall assess the project's impact on Medicaid inpatient hospital expenditures, the expenditures of other state and local government programs, access to Medicaid inpatient hospital services, quality of care, graduate medical education in the state, and access to hospital services by charity care patients.

(c) Financial and actuarial information provided by the hospital to the department for the purpose of negotiating or determining the reimbursement rate to be paid to the hospital under this provision, and any records, documents, papers, computer tapes, or other business materials obtained by the department incident to the negotiation or determination of the reimbursement rate, are proprietary confidential business information and exempt from section 119.07(1), Florida Statutes. Any meetings of the department and hospitals that are for the purpose of negotiating competitive bidding and selective contracting procedures are exempt from the provisions of section 286.011, Florida Statutes. These exemptions are subject to the Open Government Sunset Review Act in accordance with section 119.14, Florida Statutes. Any action that the department takes as a result of this competitive bidding and selective contracting shall be exempt from the Administrative Procedure Act.

(d) Data and rating information developed by the department for the purposes of negotiating or determining reimbursement rates to be paid to hospitals under this subsection, as well as the final bids that are accepted by the department, are confidential and exempt from section 119.07(1), Florida Statutes. This exemption is subject to the Open Government Sunset Review Act in accordance with section 119.14, Florida Statutes.

Section 89. Walk-in clinics; registration; prohibitions; penalties.—

(1) As used in this section, the term "walk-in clinic" means an entity that employs or contracts with licensed health care professionals to provide diagnosis or treatment services on a walk-in basis, that holds itself out as providing care on a walk-in basis, and that does not provide overnight care. This term does not apply to an entity organized under chapter 621, Florida Statutes, or a primary care center owned and operated by a hospital licensed under chapter 395, Florida Statutes, or an ambulatory surgical center licensed under chapter 395, Florida Statutes.

(2) A walk-in clinic must register annually with the Department of Health and Rehabilitative Services. A walk-in clinic may not operate without a valid registration certificate.

(a) An applicant for registration of a walk-in clinic must provide to the department, on a form established by the department, information that includes:

1. The name, location address, mailing address, and telephone numbers of each business site at which health care services are provided, or business operations are conducted, for the clinic.

2. The name, address, and telephone number of each owner and operator of the clinic and of each physician who provides health care services in connection with the clinic.

3. The names and addresses of sites at which each owner, operator, and physician has provided health care services for the 5 years preceding the application.

4. A sworn statement that no owner or operator of the clinic has been convicted of a felony or found to be a habitual misdemeanant, including any such conviction or finding in which a plea of nolo contendere was entered or adjudication was withheld, in this state or any other jurisdiction.

(b) The owner or operator of a walk-in clinic must send to the department any change in the information required under paragraph (a) within 30 days after the change occurs.

(3) The department shall issue a registration certificate to a walk-in clinic within 60 days after it receives the completed application form, unless the department has reasonable cause to believe that an owner, operator, or health care provider of the clinic is in violation of this section. If the department has such reasonable cause, it must investigate, or request that the state attorney's office investigate, the alleged violation.

(4) Health care services provided at a walk-in clinic must be provided by appropriate health care professionals who hold valid licenses to perform those services under the laws of this state.

(5) A person who has been convicted of a felony or found to be a habitual misdemeanant under the laws of this state or another state, or federal law, whether or not he has pleaded nolo contendere or had adjudication withheld, may not own or operate a walk-in clinic in this state. A violation of this subsection is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(6)(a) The department may temporarily suspend the registration of a walk-in clinic if the owner, operator, or any health care provider of the clinic is under investigation for Medicaid fraud and the department determines that such temporary suspension is necessary to protect the public health, safety, or welfare. The suspension may continue until the allegation is dismissed.

(b) The department may deny registration to, or suspend or revoke the registration of, a walk-in clinic of which an owner, operator, or health care provider has been convicted or found guilty of Medicaid fraud or of any other violation of this section.

Section 90. Section 111 of Committee Substitute for Senate Bill 2390, as passed in the 1992 Regular Session, is amended to read:

Section 111. (1) Florida Health Services Corps.—

(a) To encourage qualified medical professionals to practice in underserved locations where there are shortages of such personnel, the Legislature establishes the Florida Health Services Corps.

(b) As used in this section, the term:

1. "Department" means the Department of Health and Rehabilitative Services.

2. "Florida Health Services Corps" means a program authorized by this section which:

a. Offers scholarships to medical, chiropractic, dental, and nursing students in return for service in a public health care program.

b. Offers membership on a voluntary basis to physicians and other health care personnel ~~employed by or under contract with the department~~ who provide ~~compensated or~~ uncompensated care.

3. "Medically underserved area" means:

a. A geographic area, a special population, or a facility that has a shortage of health professionals as defined by federal regulations;

b. A county public health unit, community health center, or migrant health center; or

c. A geographic area or facility designated by rule by the department that has a shortage of health care practitioners who serve Medicaid and other low-income patients.

4. "Medically indigent person" means a person who, *as used in this section, lacks public or private health insurance, is unable to pay for health care, and is a member of a family with an income at or below 185 percent of the federal poverty level* ~~is eligible for Medicaid under state law, a migrant, a Supplemental Security Income beneficiary, a food stamp recipient, and any person the department determines is eligible for departmental health care services based on an inability to pay for some or all their care~~.

5. "Public health program" means a county public health unit, a children's medical services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded health care program designated by the department.

(c) The Florida Health Services Corps shall be developed by the State Health Office, in *cooperation with the Area Health Education Centers programs, as defined in section 381.0402, Florida Statutes, and Florida's health care education and training institutions* ~~conjunction with the Department of Education and the State University System~~. The State Health Officer shall be the director of the Florida Health Services Corps.

(d) Corps members shall be supervised by the State Health Officer, *or his physician designee,* for the purpose of practice guidelines, continuing education, and other matters pertaining to professional conduct.

(e) The department may award scholarships to students studying medicine, chiropractic, nursing, or dentistry.

1. The program shall require a student who receives a scholarship to accept an assignment in a public health care program or work in a specific community located in a medically underserved area upon graduation. The department shall determine assignments. If a practitioner is assigned to a medically underserved area, the practitioner must treat Medicaid patients and other patients with low incomes.

2. An eligible student must pursue a full-time course of study in:

a. Allopathic or osteopathic medicine, including physician assistants;

b. Dentistry;

c. Nursing, including registered nurses, nurse midwives and other nurse practitioners; or

d. Chiropractic medicine.

3. In selecting students to participate in the scholarship program, priority shall be given to students who indicate a desire to practice a primary care specialty in a medically underserved area after their obligation is completed and who indicate an intent to practice medical specialties for which the department has a need.

4. Scholarship assistance shall consist of reimbursement for tuition and other educational costs such as books, supplies, equipment, transportation, and monthly living expense stipends. The department shall pay the same amount for living expense stipends as is paid by the National Health Services Corps. Each monthly living expense stipend shall be for a 12-month period beginning with the first month of each school year in which the student is a participant. The department may reimburse a participant for books, supplies, and equipment based on average costs incurred by participants for these items. The department shall prescribe, by rule, eligible expenses for reimbursement and allowable amounts.

5. For a medical student, enrollment in the corps may begin in the second year of medical school or in any year thereafter. For a nursing student or other student, enrollment may occur in any year.

6. For a student who receives scholarship assistance, participation in the corps after graduation shall be 1 year for each school year of financial assistance, up to a maximum of 3 years. The period of obligated service shall begin when the participant is assigned by the department to a public health program or to a medically underserved area.

(g) The financial penalty for noncompliance with participation requirements shall be determined in the same manner as in the National Health Services Corps scholarship program. In addition, noncompliance with participation requirements shall also result in ineligibility for professional licensure under chapter 458, chapter 459, chapter 460, chapter 464, chapter 465, or chapter 466, Florida Statutes. For a participant who is unable to participate for reasons beyond his control, such as disability, the penalty is the actual amount of financial assistance provided to the participant. Financial penalties shall be deposited in the Florida Health Services Corps Trust Fund and shall be used to provide additional scholarship and financial assistance.

(h) Membership in the corps may be extended to any licensed physician or other health care practitioner ~~employed by, or under contract with, the department~~ who provides ~~compensated or~~ uncompensated care to medically indigent persons *referred by the department*. Participation in the corps is voluntary and subject to the supervision of the department for the purpose of practice guidelines, continuing education, and other matters pertaining to professional conduct.

(i) A Florida Health Services Corps member is an agent of the state under section 768.28(9), Florida Statutes, while providing ~~compensated or~~ uncompensated services to medically indigent persons who are referred by the department.

(j) Funds appropriated under this section shall be deposited in the Florida Health Services Corps Trust Fund, which shall be administered by the State Health Office.

(k) The department shall adopt rules to implement the Florida Health Services Corps. ~~The rules must require a corps member to provide care to a specific number of charity and Medicaid patients, require charity and Medicaid patients to comprise a minimum proportion of the patients of corps members, or require a corps member to provide a minimum amount of care, measured in dollars, to charity and Medicaid patients. If a dollar measurement is used, the calculation of a dollar value for the care delivered must be based on Medicaid reimbursement rates.~~ The rules must ~~also~~ quantify penalties for noncompliance.

(2) This section shall take effect July 1, 1992.

Section 91. Effective July 1, 1992, subsection (9) of section 768.28, Florida Statutes, as amended by section 112 of Committee Substitute in Senate Bill 2390, as passed in the 1992 Regular Session, is amended to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions.—

(9)(a) No officer, employee, or agent of the state or of any of its subdivisions shall be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. However, such officer, employee, or agent shall be considered an adverse witness in a tort action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of his employment or function. The exclusive remedy for injury or damage suffered as a result of an act, event, or omission of an officer, employee, or agent of the state or any of its subdivisions or constitutional officers shall be by action against the governmental entity, or the head of such entity in his official capacity, or the constitutional officer of which the officer, employee, or agent is an employee, unless such act or omission was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. The state or its subdivisions shall not be liable in tort for the acts or omissions of an officer, employee, or agent committed while acting outside the course and scope of his employment or committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee, or agent" includes, but is not limited to, *a* ~~any~~ member of the Florida Health Services Corps, *as defined in s. 381.90, who provides uncompensated care to medically indigent persons referred by the Department of Health and Rehabilitative Services* and any public defender or his employee or agent, including, among others, an assistant public defender and an investigator.

(c) For purposes of the waiver of sovereign immunity only, a member of the Florida National Guard is not acting within the scope of state employment when performing duty under the provisions of Title 10 or Title 32 of the United States Code or other applicable federal law; and neither the state nor any individual may be named in any action under this chapter arising from the performance of such federal duty.

Section 92. If any law other than subsection (9) of section 768.28, Florida Statutes, which is amended by this act was also amended by a law enacted at the 1992 Regular Session of the Legislature, such laws shall be construed as if they had been enacted by the same session of the Legislature, and full effect should be given to each if that is possible.

Section 93. This section shall take effect upon becoming a law, and, unless otherwise provided in this act, the other sections of this act shall take effect October 1, 1992.

And the title is amended as follows:

In title, strike everything before the enacting clause and insert: A bill to be entitled An act relating to health care; revising and reorganizing ch. 395, F.S., relating to licensing and regulation of hospitals and similar facilities; amending s. 395.002, F.S.; revising definitions related thereto; amending s. 395.003, F.S.; revising licensure provisions; amending s. 395.004, F.S.; revising procedures for application for license; providing for disposition of fees; transferring, renumbering, and amending s. 395.006, F.S.; revising provisions relating to licensure inspection; providing criteria; deleting the public records exemption provided for certain inspection reports; transferring, renumbering, and amending s. 395.008, F.S., relating to inspection reports; providing a maximum copying fee; transferring, renumbering, and amending s. 395.007, F.S.; providing for disposition of fees; deleting authority to delegate review of plans and specifications to a county or municipality; transferring, renumbering, and amending s. 395.011, F.S.; modifying provisions relating to staff membership and clinical privileges; transferring, renumbering, and amending s. 395.0115, F.S.; revising provisions related to peer review and disciplinary powers; transferring, renumbering, and amending s. 395.014, F.S.; revising provisions providing for access by chiropractors to diagnostic reports; transferring, renumbering, and amending s. 395.041, F.S., relating to internal risk management programs; limiting responsibilities of part-time risk managers; providing for annual, rather than quarterly, reports to the Department of Professional Regulation; changing procedure for reports of adverse or untoward incidents; requiring the Department of Health and Rehabilitative Services to publish an annual summary of incident reports; deleting a requirement relating to information bulletins; transferring, renumbering, and amending s. 395.0172, F.S., relating to private utilization review; deleting duplicate provisions; authorizing the department to adopt rules; transferring, renumbering, and amending s. 395.0101, F.S.; revising provisions related to the treatment of biomedical waste; transferring, renumbering, and amending s. 395.0201, F.S.; requiring certain facilities to treat and protect the anonymity of sexual assault victims; transferring, renumbering, and amending s. 395 0205, F.S.; requiring protocols for the treatment of victims of child abuse or neglect; transferring and renumbering s 395 0147, F.S., relating to notification to emergency medical personnel of exposure to infectious diseases; transferring, renumbering, and amending s. 395.038, F.S., relating to regional poison control centers; creating s. 395.103, F.S.; requiring hospital emer-

gency departments to be capable of specified communications with life support vehicles and aircraft and municipal aid channels; transferring, renumbering, and amending s. 395.0142, F.S.; expanding requirements for providing access to emergency services; providing for inventory of hospital emergency services; revising provisions relating to legislative intent, medically necessary transfers, discrimination, liability, and records; prohibiting retaliation for patient transfers; providing penalties; providing for civil actions; requiring reports; providing for treatment of emergency medical conditions of certain psychiatric patients; providing procedure for further psychiatric treatment; transferring, renumbering, and amending s. 395.0175, F.S.; revising complaint investigation procedures; providing access to certain records; transferring, renumbering, and amending s. 395.005, F.S., relating to rules and enforcement; providing for standards for the use of seclusion and restraint; providing for hospital quality improvement programs; transferring, renumbering, and amending s. 395.018, F.S.; increasing fines for operating without a license; increasing administrative fines; transferring, renumbering, and amending s. 395.015, F.S., relating to itemized patient bills; requiring certain hospitals to notify patients of their right to an itemized bill upon request; requiring hospitals to provide itemized bills when requested; providing for a copy to the physician, upon request; revising applicability; providing certain liability; transferring and renumbering s. 395.016, F.S., relating to form and content of patient records; transferring, renumbering, and amending s. 395.0165, F.S., relating to penalties for altering patient records; improving grammar; transferring, renumbering, and amending s. 395.017, F.S.; revising requirements for disclosure of patient records; providing charges for copies and searches of records; providing exemptions; limiting use and disclosure of such records; providing for additional regulatory studies to be conducted by the Department of Health and Rehabilitative Services; requiring a report; transferring, renumbering, and amending s. 395.031, F.S.; revising definitions applicable to trauma care; providing additional component of trauma care system plans; specifying a period for approval of plans; providing for hearings; transferring and renumbering s. 395.032, F.S., relating to state regional trauma planning; transferring, renumbering, and amending s. 395.033, F.S., relating to trauma service areas; conforming a cross-reference; transferring, renumbering, and amending s. 395.0335, F.S.; revising provisions relating to selection of state-approved trauma centers; revising provisions relating to notice of termination of operation; providing certain immunity from liability for out-of-state experts; transferring, renumbering, and amending s. 395.034, F.S.; revising provisions relating to reimbursement of state-sponsored trauma centers; transferring and renumbering s. 395.0345, F.S., relating to the Trauma Services Trust Fund; transferring, renumbering, and amending s. 395.035, F.S., relating to review of trauma registry data; providing for trauma transport protocols for use of air ambulance service; transferring, renumbering, and amending s. 395.036, F.S., relating to transport of trauma victims to centers; providing for trauma transport protocols for use of air ambulance service; transferring, renumbering, and amending s. 395.037, F.S., relating to rulemaking authority; conforming cross-references; transferring, renumbering, and amending s. 395.102, F.S., relating to rural hospitals; providing definitions; deleting certain limitations on rural hospital swing-bed length of stay; transferring, renumbering, and amending s. 395.103, F.S., relating to rural hospital impact statements; providing for a process by which certain rural hospitals may deactivate general hospital beds; providing for reactivation of such beds; transferring, renumbering, and amending ss. 395.104, 395.01465, F.S., relating to other rural hospital programs and emergency care hospitals, respectively; conforming cross-references; transferring, renumbering, and amending s. 395.101, F.S., relating to hospital annual assessments; providing liability for fines, penalties, and assessments upon transfer or termination of a facility; providing alternative payment method for certain statutory teaching hospitals; transferring, renumbering, and amending s. 395.1015, F.S., relating to annual assessments of other health care entities; providing an exclusion from annual assessments for certain out-of-state revenues; clarifying an exemption for blood and plasma centers; transferring, renumbering, and amending s. 395.60, F.S., relating to the short title for the Medical Education and Tertiary Care Act; conforming cross-references; transferring and renumbering s. 395.61, F.S., relating to legislative intent with respect to that act; transferring, renumbering, and amending s. 395.62, F.S., relating to the Medical Education and Tertiary Care Trust Fund; conforming a cross-reference; transferring and renumbering s. 395.63, F.S., relating to distribution of trust fund moneys; repealing ss. 395.012, 395.013, F.S., relating to prohibitions against interference with the prescription of amygdalin (laetrile) or dimethyl sulfoxide (DMSO); repealing s. 395.0141, F.S., relating to inventory of hospitals with emergency departments; repealing s. 395.0143, F.S., relating to denial of emergency treatment; repealing s. 395.0144, F.S., relating to duty to admit or transfer emergency patients; repealing s. 395.0146, F.S., relating to certificates of need for termination or reduction of emergency services; saving ss. 394.4787(4), 394.4788(2), (3), 395.001, 395.002, 395.003, 395.004, 395.005, 395.006, 395.007, 395.008, 395.009, 395.0101, 395.011, 395.0115, 395.014, 395.0142, 395.01465, 395.015, 395.016, 395.0165, 395.017, 395.0172, 395.0175, 395.018, 395.0185, 395.0201, 395.0205, 395.031, 395.032, 395.033, 395.0335, 395.034, 395.035, 395.036, 395.037, 395.038, 395.041, 395.101, 395.102, 395.103, 395.104, 395.63, F.S., from repeal October 1, 1992; amending ss. 119.07, 240.4067, 320.0801, 322.0602, 381.004, 381.026, 381.703, 381.706, 383.336, 394.4787, 394.4789, 401.425, 401.48, 407.002, 407.51, 409.918, 427.708, 440.185, 458.331, 459.015, 461.013, 468.505, 626.941, 626.943, 627.912, 641.55, 766.101, 766.110, 766.314, F.S.; conforming cross-references; amending s. 394.463, F.S., relating to involuntary examination; conforming cross-references; revising provisions related to patient transfers with respect to emergency medical conditions; revising detainment period for involuntary examination of certain patients; amending s. 154.235, F.S.; authorizing health facilities authorities to refund any revenue bonds or debt obligations issued in connection with a project; providing for the use of proceeds; amending s. 154.331, F.S.; providing procedures for dissolving county health and mental health care special districts; amending s. 196.012, F.S.; revising the definition of "nursing home" in provisions relating to property tax exemptions; providing an appropriation and for positions; amending s. 409.912, F.S.; directing the department to implement a competitive bidding demonstration project for Medicaid inpatient hospital services; providing certain exemptions from public record requirements for certain information concerning competitive bidding and selective contracting; providing an exemption from public meetings requirements for certain meetings that are held to negotiate competitive bidding and selective contracting procedures; providing an exemption from the administrative procedure act for certain actions taken by the Department of Health and Rehabilitative Services as a result of competitive bidding and selective contracting for Medicaid hospital services; providing a definition of walk-in clinic; requiring those clinics to register with the Department of Health and Rehabilitative Services; prohibiting doing business without a valid registration; requiring an applicant for registration to submit certain information; requiring the department to issue a registration certificate under certain conditions; requiring health care services to be provided by appropriate, licensed health care professionals; providing prohibitions; providing penalties; providing for temporary suspension of registration; providing for denial, suspension, or revocation of registration; amending s. 111, CS for SB 2390, enacted in the 1992 Regular Session; providing that those provisions regulating the Florida Health Services Corps only apply to health care providers furnishing uncompensated health care services to certain medically indigent persons; amending s. 768.28, F.S.; redefining the term "officer, employee, or agent" with respect to waiver of sovereign immunity; providing for construction of laws enacted at the 1992 Regular Session in relation to this act; providing effective dates.

Senator McKay moved the following amendments to **Amendment 1** which were adopted:

Amendment 1A—On page 167, strike line 10 and insert: improves access to health services.

On page 167, strike line 13 and insert: The

Amendment 1B—On page 167, line 29, before the period (.) insert: , but may not be in a county of more than 1 million population

Senator Dudley moved the following amendment to **Amendment 1** which was adopted:

Amendment 1C—On page 6, strike line 27 and insert: *facility, as well as other licensed health care professionals who have*

Amendment 1 as amended was adopted.

On motion by Senator Malchon, by two-thirds vote **HB 43-E** as amended was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—40 Nays—None

SB 44-E—A bill to be entitled An act relating to health care; creating s. 766.1115, F.S.; creating the "Access to Health Care Act"; providing legislative intent; authorizing the Department of Health and Rehabilitative Services to execute contracts with specified health care providers for delivery of uncompensated health care services as an agent of the state;

providing definitions; requiring agency contracts; specifying terms; providing for the contractor's right of termination or dismissal; providing for access to patient records by contractor; requiring adverse incident and treatment outcome reporting; exempting from public records law patient records, adverse incident reports, and patient treatment outcome information obtained by the contractor; providing for patient referral by contractor; providing for uncompensated care; requiring certain notice of agency relationship; requiring a quality assurance program; requiring the Department of Insurance to compile a claims report; providing for reporting; providing responsibility for certain costs of malpractice litigation; providing for rulemaking by the Department of Health and Rehabilitative Services; exempting contracts by the Department of Corrections; providing applicability; providing for review and repeal; amending s. 768.13, F.S., the "Good Samaritan Act"; providing immunity for emergency medical service providers who provide medical care at the scene of an emergency, under certain circumstances; amending s. 768.28, F.S.; providing sovereign immunity to providers of health care services pursuant to agency contracts with governmental contractors; reenacting ss. 766.203(1), 766.207(1), F.S., relating to presuit investigation and voluntary binding arbitration of medical and negligence claims, to incorporate the amendment to s. 768.28, F.S., in references thereto; amending ss. 627.6415, 627.6578, F.S.; requiring that health insurance policies provide benefits for children placed in court-ordered custody of the insured without preexisting condition exclusion; providing appropriations; providing for construction of laws enacted at the 1992 Regular Session in relation to this act; providing an effective date.

—was read the second time by title.

Five amendments were adopted to **SB 44-E** to conform the bill to **HB 61-E**.

Pending further consideration of **SB 44-E** as amended, on motions by Senator Grant, by two-thirds vote **HB 61-E** was withdrawn from the Committees on Health and Rehabilitative Services; and Appropriations.

On motions by Senator Grant, by two-thirds vote—

HB 61-E—A bill to be entitled An act relating to health care; creating s. 766.1115, F.S.; creating the "Access to Health Care Act"; providing legislative intent; authorizing the Department of Health and Rehabilitative Services to execute contracts with specified health care providers for delivery of uncompensated health care services as an agent of the state; providing definitions; requiring agency contracts; specifying terms; providing for the contractor's right of termination or dismissal; providing for access to patient records by contractor; requiring adverse incident and treatment outcome reporting; exempting from public records law patient records, adverse incident reports, and patient treatment outcome information obtained by the contractor; providing for patient referral by contractor; providing for uncompensated care; requiring certain notice of agency relationship; requiring a quality assurance program; requiring the Department of Insurance to compile a claims report; providing for reporting; providing responsibility for certain costs of malpractice litigation; providing for rulemaking by the Department of Health and Rehabilitative Services; exempting contracts by the Department of Corrections; providing applicability; providing for review and repeal; amending s. 768.28, F.S.; providing sovereign immunity to providers of health care services pursuant to agency contracts with governmental contractors; reenacting ss. 766.203(1), 766.207(1), F.S., relating to presuit investigation and voluntary binding arbitration of medical and negligence claims, to incorporate the amendment to s. 768.28, F.S., in references thereto; amending ss. 627.6415, 627.6578, F.S.; requiring that health insurance policies provide benefits for children placed in court-ordered custody of the insured without preexisting condition exclusion; providing appropriations; providing for construction of laws enacted at the 1992 Regular Session in relation to this act; revising provisions relating to the Florida Health Services Corps; amending s. 768.28, F.S.; revising a definition; providing an effective date.

—a companion measure, was substituted for **SB 44-E** and by two-thirds vote read the second time by title.

Senator Grant moved the following amendments which were adopted:

Amendment 1—On page 12, line 22, strike "*6 and 7*" and insert: *5 and 6*

Amendment 2—On page 17, line 29, strike "Paragraph" and insert: Effective July 1, 1992, paragraph

On motion by Senator Grant, by two-thirds vote **HB 61-E** as amended was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—40 Nays—None

SB 28-E—A bill to be entitled An act relating to environmental resources; amending s. 380.20, F.S.; revising the short title; creating s. 380.205, F.S.; providing definitions; amending ss. 380.21 and 380.22, F.S.; transferring lead agency authority under the Coastal Zone Management Act from the Department of Environmental Regulation to the Department of Community Affairs; amending s. 380.23, F.S.; providing for the transfer of authority; providing for final consistency determinations to be made by the Governor under certain circumstances for a limited time; amending s. 380.33, F.S.; designating the Secretary of Community Affairs as the chairperson of the Coastal Resources Interagency Management Committee and the Secretary of Environmental Regulation as the vice chairperson; providing for the Department of Community Affairs to provide staff to the committee; continuing ss. 380.31, 380.32, and 380.33, F.S., relating to the Coastal Resources Interagency Management Committee, notwithstanding their scheduled repeal; repealing ss. 380.31, 380.32, and 380.33, F.S., effective October 1, 1994; providing for review by the Legislature prior thereto; transferring the state coastal management program functions to the Department of Community Affairs; providing for a position; repealing ss. 380.19 and 380.28, F.S., relating to the Florida Coastal Coordinating Council and relating to the South Atlantic and Gulf States Coastal Protection Compact; providing an effective date.

—was read the second time by title.

Senators Kiser and Kirkpatrick offered the following amendments which were moved by Senator Kirkpatrick and adopted:

Amendment 1 (with Title Amendment)—On page 5, between lines 15 and 16, insert:

Section 6. Section 380.31, Florida Statutes, is amended to read:

380.31 Coastal Resources Interagency Management Committee established.—There is established a Coastal Resources Interagency Management Committee composed of: the Secretary of Commerce, the Secretary of Community Affairs, the Secretary of Environmental Regulation, *the Secretary of Labor and Employment Security,* the Secretary of Transportation, the Assistant State Health Officer for Environmental Health in the Department of Health and Rehabilitative Services, the executive director of the Department of Natural Resources, the executive director of the Marine Fisheries Commission, the executive director of the Game and Fresh Water Fish Commission, the director of the Division of Historical Resources of the Department of State, the director of the Division of Forestry of the Department of Agriculture and Consumer Services, and the director of the Governor's Office of Planning and Budgeting. Each member shall attend the meetings of the committee or appoint a designee. A designee *must* ~~shall~~ be a policymaking administrator who *may* ~~can~~ speak for the agency.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 1, line 13, after the semicolon (;) insert: amending s. 380.31, F.S.; adding the Secretary of Labor and Employment Security to the membership of the Coastal Resources Interagency Management Committee;

Amendment 2 (with Title Amendment)—On page 6, between lines 23 and 24, insert:

Section 10. Notwithstanding the provisions of chapter 216, no state agency shall seek additional positions or spending authority in fiscal year 1992-1993 for purposes relating to the coastal zone management program administered by the U. S. Office of Coastal Zone Management in addition to any positions or spending authority approved in the fiscal year 1992-1993 general appropriations act.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 1, line 30, after the semicolon (;) insert: prohibiting any state agency from seeking positions or spending authority in fiscal year 1992-1993 for the coastal zone management program in excess of that approved in the fiscal year 1992-1993 general appropriations act;

Senator Langley moved the following amendment:

Amendment 3—On page 6, line 4, insert:

Section 7. Paragraph (d) of subsection (10) of section 163.3177, Florida Statutes, is amended to read:

163.3177 Required and optional elements of comprehensive plans; Studies and surveys.—

(d) Chapter 9J-5, F.A.C. *and this chapter do* ~~does~~ not mandate the creation, limitation, or elimination of regulatory authority, nor does it authorize the adoption or require the repeal of any rules, criteria, or standards of any local, regional, or state agency. *The state land planning agency shall not require a local government to exceed the requirements of a state law or rule within the regulatory jurisdiction of another state agency.*

(Renumber subsequent sections.)

POINT OF ORDER

Senator Kiser raised a point of order that pursuant to Rule 7.1 **Amendment 3** was not germane to the bill.

RULING ON POINT OF ORDER

On recommendation of Senator Thomas, Chairman of the Committee on Rules and Calendar, the President ruled the point well taken and the amendment out of order.

Senator Grizzle moved the following amendment:

Amendment 4—On page 6, line 28, insert a new Section 12:

Section 12. Commercial marina permits issued pursuant to chapter 403, Florida Statutes, Public Law 92-500, Florida Administrative Code, chapter 17-312 and chapter 17-25, and issued after January 1, 1990 and prior to January 1, 1992, are hereby extended for one year.

(Renumber subsequent sections.)

POINT OF ORDER

Senator Kirkpatrick raised a point of order that pursuant to Rule 7.1 **Amendment 4** was not germane to the bill.

RULING ON POINT OF ORDER

On recommendation of Senator Thomas, Chairman of the Committee on Rules and Calendar, the President ruled the point well taken and the amendment out of order.

On motion by Senator Kiser, by two-thirds vote **SB 28-E** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—37 Nays—2

SB 10-E—A bill to be entitled An act relating to mortgage foreclosure; amending s. 45.031, F.S.; changing the time for sale of property by the clerk of the court; creating s. 45.0315, F.S.; providing for right of redemption; providing for limitations upon such rights; amending s. 48.021, F.S.; providing for process to be served by a party or party's attorney; amending s. 48.193, F.S.; expanding the jurisdiction of courts of the state to persons holding a mortgage or lien on certain property; amending s. 48.194, F.S.; providing for alternative service of process in foreclosure proceedings; amending s. 48.23, F.S.; providing for exceptions to the application of lis pendens; amending s. 49.021, F.S.; providing for a cross-reference; amending s. 49.09, F.S.; revising provisions with respect to the return day notice of action; providing a time limit; amending s. 49.10, F.S.; reducing the required number of publications of notice in foreclosure proceedings; amending s. 55.01, F.S.; providing for social security numbers to be included on judgments; amending s. 55.10, F.S.; providing for the address of the person holding a lien to be recorded; providing for application; amending s. 55.505, F.S ; providing for inclusion of social security numbers in notice of recording; amending s. 494.0019, F.S.; revising provisions with respect to liability in the case of an unlawful mortgage transaction; limiting liability; amending s. 494.006, F.S.; providing an exemption from mortgage lending licensing requirements for insurance companies; amending s. 697.07, F.S.; providing for rents to be assigned to a mortgagee; providing a process for rents to be deposited; providing for distribution of rents; amending s. 702.09, F.S.; providing definitions; creating s. 702.10, F.S.; providing for an order to show cause in foreclosure proceedings; providing for entry of final judgment in foreclosure proceedings; creating s. 702.11, F.S.; providing for defenses in foreclosure proceedings; providing for construction of laws enacted at the 1992 Regular Session in relation to this act; providing severability; providing an effective date.

—was read the second time by title.

The Committee on Judiciary recommended the following amendments which were moved by Senator Yancey and adopted:

Amendment 1—On page 18, line 28, after "payments of" insert: unaccelerated

Amendment 2 (with Title Amendment)—On page 19, between lines 18 and 19, insert:

Section 20. Section 701.04 is amended to read:

701.04 Cancellation of mortgages, liens, and judgments.—*Within fourteen days, and upon the written request of a mortgagor, the holder of a mortgage shall deliver in the county in which the mortgage is recorded, an estoppel letter together with a per diem rate.* Whenever the amount of money due on any mortgage, lien, or judgment shall be fully paid to the person or party entitled to the payment thereof, the mortgagee, creditor, or assignee, or the attorney of record in the case of a judgment, to whom such payment shall have been made, shall execute in writing an instrument acknowledging satisfaction of said mortgage, lien, or judgment and have the same acknowledged, or proven, and duly entered of record in the book provided by law for such purposes in the proper county. Within 60 days of the date of receipt of the full payment of the mortgage, lien, or judgment, the person required to acknowledge satisfaction of the mortgage, lien, or judgment shall send or cause to be sent the recorded satisfaction to the person who has made the full payment. In the case of a civil action arising out of the provisions of this section, the prevailing party shall be entitled to attorney's fees and costs.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 2, line 14, after the semicolon (;) insert: amending s. 701.04, F.S.; requiring delivery of an estoppel letter;

Senators Yancey and Dudley offered the following amendment which was moved by Senator Dudley and adopted:

Amendment 3 (with Title Amendment)—On page 15, line 9, through page 16, line 5, strike all of said lines and renumber subsequent sections.

And the title is amended as follows:

In title, on page 2, strike all of lines 9 and 10 and insert: creating s. 702.10, F.S.;

Senators Yancey and Dudley offered the following amendment which was moved by Senator Yancey and adopted:

Amendment 4—On page 17, line 5, through page 19, line 16, strike all of said lines and insert:

(e) State that, if the defendant fails to appear at the show cause hearing and fails to file a verified or sworn answer or defenses, he or she may be deemed to have waived the right to a hearing and in such case the court may enter a final judgment of foreclosure ordering the clerk of the court to conduct a foreclosure sale.

(f) Attach the final judgment of foreclosure the court will enter, if the defendant waives his or her right to be heard at the order to show cause hearing.

(g) Require the mortgagee's attorney, or the mortgagee if not represented by an attorney, to:

1. Make reasonable efforts to provide the defendant with notice of the order to show cause hearing.

2. Certify to the court in writing at the show cause hearing the efforts which have been made to give such notice.

Any order to show cause rendered pursuant to this section shall be served on the defendant as provided by law. Any final judgment of foreclosure entered under this section shall be for in rem relief only.

(2) The right to be heard at the show cause hearing is waived if the defendant, after being served as provided by law with a show cause order, engages in conduct that clearly shows that he or she has relinquished his or her right to be heard on that order. The defendant's failure to file a sworn or verified answer or defenses and to appear at the hearing duly scheduled on the order to show cause presumptively constitutes conduct that clearly shows that he or she has relinquished his or her right to be heard. If a defendant files or submits a verified or sworn answer or defenses at or before the hearing, such action constitutes "cause" under subsection (3) and shall preclude the entry of a final judgment at the show cause hearing.

(3) If the court finds that the defendant has waived the right to be heard as provided in subsection (2), the court may promptly issue the final judgment of foreclosure that was attached to the order to show cause. If the court finds that the defendant has not waived his or her right to be heard on the order to show cause, the court shall then determine whether there is cause not to enter the final judgment of foreclosure that was attached to the order to show cause. If the court finds that the defendant has not shown cause, the court may promptly issue the judgment of foreclosure that was attached to the order to show cause.

Section 1. Section 702.11, Florida Statutes, is created to read:

702.11 Defenses in foreclosure proceedings.—

(1) In the event the owner of the interest being foreclosed interposes any defense to the foreclosure proceedings other than payment of the indebtedness, the court may, upon motion, by either party, in circumstances where material detriment to a party may occur during the pendency of the foreclosure proceedings, order the owner of the real property to pay into the registry of the court, or other depository as determined by the court, the unaccelerated accrued payments of principal and interest that are in default and may order the payments of unaccelerated principal and interest which accrue during the pendency of the foreclosure proceedings to be paid or order such other amount as the court may determine in its discretion. In determining whether to require payment and the amount to be paid pursuant to this section, the court shall consider whether the owner or mortgagor has the use or benefit of the property and all other matters that would be proper for consideration by a court of equity.

(2) All monies deposited pursuant to this section, plus any interest, shall be disbursed in accordance with the court's final judgment or decree. The fee of the clerk of the court or any other depository shall be paid by the party requesting that the payments be required or permitted to be paid into the registry or depository.

Senator Dudley moved the following amendment which was adopted:

Amendment 5—On page 19, line 2, after "shall consider" insert: the likelihood of success on the merits by the owner or mortgagor,

Senator Johnson moved the following amendment which was adopted:

Amendment 6 (with Title Amendment)—On page 19, between lines 18 and 19, insert:

Section 20. Section 701.04 is amended to read:

701.04 Cancellation of mortgages, liens, and judgments.—*Within fourteen days after receipt of the written request of a mortgagor, the holder of a mortgage shall deliver to the mortgagor at a place designated in the written request an estoppel letter setting forth the unpaid principal balance, interest due, and the per diem rate.* Whenever the amount of money due on any mortgage, lien, or judgment shall be fully paid to the person or party entitled to the payment thereof, the mortgagee, creditor, or assignee, or the attorney of record in the case of a judgment, to whom such payment shall have been made, shall execute in writing an instrument acknowledging satisfaction of said mortgage, lien, or judgment and have the same acknowledged, or proven, and duly entered of record in the book provided by law for such purposes in the proper county. Within 60 days of the date of receipt of the full payment of the mortgage, lien, or judgment, the person required to acknowledge satisfaction of the mortgage, lien, or judgment shall send or cause to be sent the recorded satisfaction to the person who has made the full payment. In the case of a civil action arising out of the provisions of this section, the prevailing party shall be entitled to attorney's fees and costs.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 2, line 14, after the semicolon (;) insert: amending s. 701.04, F.S.; requiring delivery of an estoppel letter;

Senator McKay moved the following amendment which was adopted:

Amendment 7—On page 19, between lines 29 and 30, insert:

Section 22. The provisions of this act shall apply only to nonresidential mortgages executed after October 1, 1992.

(Renumber subsequent sections.)

The vote was:

Yeas—30 Nays—9

Senator Wexler moved the following amendment:

Amendment 8 (with Title Amendment)—On page 19, between lines 29 and 30, insert:

Section 22. Notwithstanding any other provision of law, this act does not apply to residential property.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 2, line 18, after the semicolon (;) insert: providing for applicability;

On motion by Senator Yancey, further consideration of **SB 10-E** with pending **Amendment 8** was deferred.

SB 26-E—A bill to be entitled An act relating to governmental reorganization; abolishing the Department of Administration and transferring its duties to other agencies; amending s. 20.22, F.S.; renaming the Department of General Services as the Department of Management Services and providing that the head of the department is a Secretary of Management Services appointed by the Governor; transferring the Division of Bond Finance from the Department of General Services to the State Board of Administration; transferring personnel, records, property, and unexpended balances of appropriations of the Department of General Services used to support the Office of Executive Clemency to the Florida Parole Commission; making the Division of Surplus Property a bureau within the Division of Purchasing; amending ss. 11.25, 11.44, 20.04, 20.23, 24.120, 110.107, 110.109, 110.1097, 110.1127, 110.1128, 110.116, 110.117, 110.121, 110.123, 110.1231, 110.1232, 110.1234, 110.1245, 110.1246, 110.125, 110.131, 110.151, 110.1522, 110.161, 110.171, 110.205, 110.2135, 110.215, 110.227, 110.233, 110.403, 110.405, 110.407, 110.503, 110.607, 112.0455, 112.08, 112.0804, 112.24, 112.3173, 112.352, 112.361, 112.363, 112.63, 112.665, 120.52, 120.65, 121.021, 121.025, 121.031, 121.0515, 121.055, 121.071, 121.135, 121.136, 121.35, 121.40, 122.02, 122.03, 122.09, 122.13, 122.23, 122.34, 123.01, 123.07, 123.11, 123.24, 123.25, 123.36, 132.34, 145.19, 154.04, 163.3184, 189.4035, 189.412, 189.421, 210.20, 210.75, 215.425, 215.515, 215.94, 215.96, 216.011, 216.0165, 216.262, 218.32, 230.23, 231.262, 231.36, 238.01, 238.03, 238.08, 238.11, 240.209, 240.343, 242.68, 250.22, 252.38, 253.126, 266.0006, 266.0016, 266.0026, 266.0036, 266.0046, 266.0056, 266.0066, 284.36, 287.17, 295.11, 321.04, 321.17, 321.19, 321.191, 321.202, 321.2205, 337.165, 350.0614, 350.125, 370.0821, 376.10, 381.709, 402.35, 403.061, 406.075, 408.001, 409.029, 443.131, 455.225, 650.02, 760.04, F.S.; conforming such sections to the abolition of the Department of Administration; amending ss. 11.148, 11.45, 14.057, 20.32, 24.105, 27.34, 27.54, 75.05, 110.173, 120.53, 159.345, 159.475, 159.7055, 159.803, 212.055, 215.422, 215.47, 215.62, 215.93, 215.94, 216.0152, 216.016, 216.044, 216.0445, 216.163, 216.292, 217.01, 217.02, 217.04, 217.045, 218.32, 218.37, 218.38, 229.8052, 235.018, 235.26, 240.225, 240.417, 240.441, 253.45, 255.02, 255.043, 255.05, 255.21, 255.245, 255.25, 255.253, 255.258, 255.259, 255.28, 255.29, 255.30, 255.45, 255.451, 255.502, 255.506, 255.518, 255.555, 255.565, 259.03, 265.284, 265.285, 265.2865, 267.061, 270.27, 272.03, 272.04, 272.05, 272.06, 272.07, 272.08, 272.09, 272.12, 272.121, 272.122, 272.124, 272.129, 272.16, 272.161, 272.18, 272.185, 273.04, 273.05, 273.055, 281.02, 281.07, 282.102, 282.1021, 282.103, 282.105, 282.1095, 282.111, 282.304, 282.3061, 282.3062, 282.307, 282.308, 282.309, 282.311, 282.314, 282.318, 282.402, 282.403, 283.30, 284.01, 284.04, 284.05, 284.08, 284.385, 284.42, 285.06, 285.14, 287.012, 287.025, 287.032, 287.042, 287.055, 287.057, 287.0572, 287.0595, 287.064, 287.073, 287.0834, 287.0943, 287.0945, 287.133, 287.15, 287.151, 287.155,

287.16, 288.13, 288.14, 288.15, 288.17, 288.18, 288.23, 288.24, 288.28, 288.281, 288.31, 288.33, 288.703, 288.704, 288.705, 320.0802, 327.25, 336.025, 337.02, 337.276, 338.227, 341.101, 341.322, 344.17, 348.0002, 348.241, 348.52, 348.755, 348.765, 348.94, 348.941, 348.963, 348.966, 349.05, 365.171, 373.4596, 377.703, 380.0662, 401.013, 401.015, 403.1834, 403.1835, 403.712, 403.714, 403.7145, 413.034, 420.503, 420.608, 553.77, 570.50, 627.096, 940.03, 943.03, 944.10, 944.713, 946.504, 946.515, F.S.; conforming such sections to the renaming of the Department of Management Services and to the transfer of certain of the department's duties; repealing s. 20.31, F.S., relating to the Department of Administration; repealing s. 112.192, F.S., relating to the State Officers' Compensation Commission; repealing s. 215.58(5), F.S., relating to a definition of the term "department"; providing for a study of certain functions of decisions in the Department of General Services; providing for continuation of rules of agencies involved in reorganization; providing for substitution of agencies in pending proceedings; providing for assumption of powers and duties under conflicting laws enacted in the same session; providing for construction of laws enacted at the 1992 Regular Session in relation to this act; providing an effective date.

—was read the second time by title.

The Committee on Appropriations recommended the following amendments which were moved by Senator Malchon and adopted:

Amendment 1—On page 5, lines 4 and 5, strike "and assigned to the Division of State Employees' Insurance"

Amendment 2—On page 88, lines 24 and 25, and on page 96, lines 30 and 31, strike "~~Department of~~ Administration *Commission*" and insert: Department of *Management Services* ~~Administration~~

The Committee on Appropriations recommended the following amendment which was moved by Senator Malchon:

Amendment 3—On page 247, strike all of lines 2 and 3 and insert: members representing state agencies, including two who must represent agencies headed by the Governor and Cabinet and one who must represent state workers. The

Senator McKay moved that further consideration of **SB 26-E** with pending **Amendment 3** be deferred. The motion was adopted. The vote was:

Yeas—20 Nays—19

MOTION TO RECONSIDER

Senator Childers moved that the Senate reconsider the vote by which the motion to defer further consideration of **SB 26-E** as amended was adopted. The motion failed. The vote was:

Yeas—19 Nays—20

REPORTS OF COMMITTEES

The Committee on Rules and Calendar submits the following bills to be placed on the Special Order Calendar for Tuesday, March 31, 1992: HB 43-E, SB 44-E, SB 28-E, SB 10-E, SB 26-E

Respectfully submitted,
Pat Thomas, Chairman

MESSAGES FROM THE HOUSE OF REPRESENTATIVES

FIRST READING

The Honorable Gwen Margolis, President

I am directed to inform the Senate that the House of Representatives has admitted for introduction by the required Constitutional two-thirds vote, passed HB 61-E as amended, and requests the concurrence of the Senate.

John B. Phelps, Clerk

By Representative Albright—

HB 61-E—A bill to be entitled An act relating to health care; creating s. 766.1115, F.S.; creating the "Access to Health Care Act"; providing legislative intent; authorizing the Department of Health and Rehabilitative Services to execute contracts with specified health care providers for delivery of uncompensated health care services as an agent of the state; providing definitions; requiring agency contracts; specifying terms; providing for the contractor's right of termination or dismissal; providing for access to patient records by contractor; requiring adverse incident and treatment outcome reporting; exempting from public records law patient records, adverse incident reports, and patient treatment outcome information obtained by the contractor; providing for patient referral by contractor; providing for uncompensated care; requiring certain notice of agency relationship; requiring a quality assurance program; requiring the Department of Insurance to compile a claims report; providing for reporting; providing responsibility for certain costs of malpractice litigation; providing for rulemaking by the Department of Health and Rehabilitative Services; exempting contracts by the Department of Corrections; providing applicability; providing for review and repeal; amending s. 768.28, F.S.; providing sovereign immunity to providers of health care services pursuant to agency contracts with governmental contractors; reenacting ss. 766.203(1), 766.207(1), F.S., relating to presuit investigation and voluntary binding arbitration of medical and negligence claims, to incorporate the amendment to s. 768.28, F.S., in references thereto; amending ss. 627.6415, 627.6578, F.S.; requiring that health insurance policies provide benefits for children placed in court-ordered custody of the insured without preexisting condition exclusion; providing appropriations; providing for construction of laws enacted at the 1992 Regular Session in relation to this act; revising provisions relating to the Florida Health Services Corps; amending s. 768.28, F.S.; revising a definition; providing an effective date.

On motion by Senator Grant, by the required Constitutional two-thirds vote of the Senate, **HB 61-E** was admitted for introduction and referred to the Committees on Health and Rehabilitative Services; and Appropriations.

ROLL CALLS ON SENATE BILLS

SB 10-E—Amendment 7

Yeas—30

Bankhead	Davis	Kirkpatrick	Scott
Beard	Diaz-Balart	Kiser	Souto
Bruner	Forman	Langley	Thomas
Burt	Gardner	Malchon	Thurman
Casas	Gordon	McKay	Walker
Childers	Grant	Meek	Wexler
Crenshaw	Grizzle	Myers	
Crotty	Jenne	Plummer	

Nays—9

Madam President	Girardeau	Weinstein
Dantzler	Johnson	Weinstock
Dudley	Kurth	Yancey

SB 26-E
Motion to Defer Consideration

Yeas—20

Bankhead	Crotty	Jennings	McKay
Bruner	Diaz-Balart	Johnson	Myers
Burt	Dudley	Kirkpatrick	Plummer
Childers	Grant	Kiser	Scott
Crenshaw	Grizzle	Langley	Souto

Nays—19

Madam President	Forman	Kurth	Weinstein
Beard	Gardner	Malchon	Weinstock
Casas	Girardeau	Meek	Wexler
Dantzler	Gordon	Thomas	Yancey
Davis	Jenne	Walker	

SB 26-E
Reconsideration of Vote to Defer Consideration

Yeas—19

Madam President	Forman	Kurth	Weinstein
Beard	Gardner	Malchon	Weinstock
Casas	Girardeau	Meek	Wexler
Dantzler	Gordon	Thomas	Yancey
Davis	Jenne	Thurman	

Nays—20

Bankhead	Crotty	Johnson	Myers
Bruner	Dudley	Kirkpatrick	Plummer
Burt	Grant	Kiser	Scott
Childers	Grizzle	Langley	Souto
Crenshaw	Jennings	McKay	Walker

SB 28-E

Yeas—37

Madam President	Davis	Johnson	Thomas
Bankhead	Diaz-Balart	Kirkpatrick	Thurman
Beard	Dudley	Kiser	Walker
Bruner	Forman	Kurth	Weinstein
Burt	Gardner	Langley	Weinstock
Casas	Girardeau	McKay	Wexler
Childers	Gordon	Meek	Yancey
Crenshaw	Grant	Myers	
Crotty	Jenne	Scott	
Dantzler	Jennings	Souto	

Nays—2

Grizzle	Plummer

Vote after roll call:

Yea—Malchon

SR 46-E

Yeas—32

Bankhead	Dantzler	Grizzle	Myers
Beard	Diaz-Balart	Jennings	Plummer
Bruner	Dudley	Johnson	Scott
Burt	Forman	Kirkpatrick	Souto
Casas	Gardner	Kiser	Thomas
Childers	Girardeau	Kurth	Thurman
Crenshaw	Gordon	Langley	Walker
Crotty	Grant	McKay	Weinstein

Nays—7

Madam President	Malchon	Weinstock	Yancey
Jenne	Meek	Wexler	

Vote after roll call:

Nay—Davis

ROLL CALLS ON HOUSE BILLS

HB 43-E

Yeas—40

Madam President	Davis	Jennings	Plummer
Bankhead	Diaz-Balart	Johnson	Scott
Beard	Dudley	Kirkpatrick	Souto
Bruner	Forman	Kiser	Thomas
Burt	Gardner	Kurth	Thurman
Casas	Girardeau	Langley	Walker
Childers	Gordon	Malchon	Weinstein
Crenshaw	Grant	McKay	Weinstock
Crotty	Grizzle	Meek	Wexler
Dantzler	Jenne	Myers	Yancey

Nays—None

HB 61-E

Yeas—40

Madam President	Davis	Jennings	Plummer
Bankhead	Diaz-Balart	Johnson	Scott
Beard	Dudley	Kirkpatrick	Souto
Bruner	Forman	Kiser	Thomas
Burt	Gardner	Kurth	Thurman
Casas	Girardeau	Langley	Walker
Childers	Gordon	Malchon	Weinstein
Crenshaw	Grant	McKay	Weinstock
Crotty	Grizzle	Meek	Wexler
Dantzler	Jenne	Myers	Yancey

Nays—None

ROLL CALLS ON MOTIONS

Motion to Adjourn Sine Die

Yeas—20

Bankhead	Crenshaw	Grizzle	McKay
Beard	Crotty	Jennings	Myers
Bruner	Diaz-Balart	Johnson	Plummer
Burt	Dudley	Kiser	Scott
Casas	Grant	Langley	Souto

Nays—20

Madam President	Gardner	Kurth	Walker
Childers	Girardeau	Malchon	Weinstein
Dantzler	Gordon	Meek	Weinstock
Davis	Jenne	Thomas	Wexler
Forman	Kirkpatrick	Thurman	Yancey

Motion to Adjourn Sine Die

Yeas—35

Madam President	Dantzler	Kirkpatrick	Souto
Bankhead	Davis	Kiser	Thomas
Beard	Dudley	Langley	Thurman
Bruner	Gardner	Malchon	Walker
Burt	Gordon	McKay	Weinstein
Casas	Grant	Meek	Weinstock
Childers	Grizzle	Myers	Wexler
Crenshaw	Jennings	Plummer	Yancey
Crotty	Johnson	Scott	

Nays—4

Forman	Girardeau	Jenne	Kurth

ENROLLING REPORTS

SR 46-E has been presented to the Governor on March 31, 1992.

Joe Brown, Secretary

CORRECTION AND APPROVAL OF JOURNAL

The Journal of March 30 was corrected and approved.

ADJOURNMENT

Senator Thomas moved that the Senate adjourn sine die. The motion was adopted and the Senate adjourned sine die at 3:48 p.m. The vote was: Yeas—35 Nays—4